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ABSTRACT

A follow-up to the National Association of School Psychologists' "Helping Children Grow up in the 1990's," this collection of handouts represents updated, revised, and newly developed resources addressing many children's issues faced by families and educators. Organized in loose-leaf format, these handouts are designed to be individually photocopied and given by school psychologists to parents, teachers, administrators, and others working with children. The intention of these handouts is to help make a difference in the lives of children to foster their success as adults and parents of the next generation. Each handout includes general information about the topic, its relation to child development and strategies for supporting children at home and at school. The handouts are not intended to be comprehensive reports or detailed prescriptions, but to provide sufficient information to clarify important issues, initial steps to take in addressing a problem, and suggestions for further courses of action. (MKA)

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Helping Children at Home and School:

Handouts From Your School Psychologist

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and Servio A. Carroll

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CG028528

Helping Children at Home and School

Handouts from Your School Psychologist

Edited by
Andrea S. Canter and Servio A. Carroll

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Foreword and Acknowledgments

Virginia Linger Wright, Ed.D. (1912-1995), Wyoming educator, pioneer school psychologist and state legislator, once said that the greatest honor she had ever received was "parents entrusting their children to her care." This resource book has been developed with the assistance of over 100 school psychologists and allied professionals — all experts in their fields — to address many children's issues faced by families and educators. Organized in loose-leaf format, these handouts are designed to be individually photocopied and given to parents, teachers, administrators and others working with children "entrusted in our care." It is our intention that these handouts, in some small way, will help make a difference in the lives of these children so they may become successful as adults and parents of the next generation.

In 1992, the National Association of School Psychologists published its first collection of handouts for parents and educators, *Helping Children Grow Up in the 1990s*. On the brink of a new millennium of challenges facing children, parents and teachers, this collection represents updated, revised and newly developed resources. Each handout includes general information about the topic, its relation to child development, and strategies for supporting children at home and at school. The handouts are not intended to be comprehensive reports or detailed prescriptions, but to provide sufficient information to clarify important issues, initial steps to take in addressing a problem and suggestions for further courses of action. For more detail, readers are encouraged to investigate the resources included with each handout. Some of these handouts have been published recently in the NASP newspaper, *Communiqué*.

As with any book of this magnitude, a great number of individuals have had a hand in its development and production. We gratefully acknowledge the contributing authors and reviewers who spent the time to share their expertise for the benefit of our children, families and schools (see list); the NASP Publications Board (especially Leslie Z. Paige, Chair) and the NASP Executive Council for their support and guidance; C. Paul Mendez, NASP Director of Publications, for his production and marketing expertise, as well as his guidance, humor and patience; Susan Gorin, NASP Executive Director, for her continued encouragement and support; Professor Phyllis Anne Teeter of the University of Wisconsin-Milwaukee School Psychology Program, whose students have contributed a number of outstanding handouts to this project and the *Communiqué;* Elizabeth Conner and Jay Folie (Conner and Company) for providing timely and expert graphic design and layout services under harried circumstances; Ivonne Romero, Bradley Pilon, Doris Paez and their colleagues for Spanish language translations of several handouts. We also want to acknowledge our supportive families, friends and colleagues:

From Andrea Canter — Having protected my family and friends from most of the hassles of this project, I do want to thank my mother (Miriam) who taught me the basics of editing even when I didn't realize what she was up to; my father (Arthur) who first mentioned the words "school psychology" to me as I set a freshman foot on the University of Iowa campus; my brother (Larry) who continually confirmed that my computer (like me) had insufficient memory to handle such a task; my friend and physical therapist, Chris Hazelton, whose professional skill and patience never waned despite my efforts to counteract treatment with hours at the computer; graphic designers Elizabeth Conner and Jay Folie who quickly realized we were in over our heads and didn't let on; Leslie Paige who was never too busy to read, revise, edit or encourage; NASP President Deborah Crockett and Executive Director Susan Gorin for expecting me to rise to the occasion; and my buddy and co-editor Servio Carroll for staying calm when there was no apparent reason.

From Servio Carroll — To my wife, best friend and strongest supporter, Mary, our girls Wendy, Kelly and Shea, and my mother, Adelaida: Thank you for your understanding, unending support, and perennial willingness to quickly respond to: "…will you take a look at this?" Also, thank you for your willingness to accept the countless hours spent at the computer and on the telephone. Thank you to Phil Dorsch, Bob Bayuk, Tom Tynan, Lynn Hamersly, Deborah Crockett, Alex Thomas, Diane Smallwood, Howie Knoff, George Batsche and Andrea Canter for the opportunities, support and encouragement offered throughout this endeavor.

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April, 1998

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Allowance

Guidelines for Parents

by Fred Provenzano, Ph.D., NCSP, University of Washington
and Janet Bodnar, Senior Editor, *Kiplinger's Personal Finance Magazine*

Introduction

In these times of great discretionary spending, the responsible management of money is one of the most important skills needed for successful adulthood. No matter how much or how little money your children earn as adults, they will need to know how to live within their means to avoid money problems. An allowance gives your children experience with managing money, setting spending priorities, and budgeting for expensive items. It not only helps them to appreciate the power of money, but also the limits and consequences of fiscal behavior.

When Should My Children Begin to Receive an Allowance?

Your child needs to be old enough for money to be meaningful (or, as one parent put it, old enough not to eat it!). Children should be aware that items in stores need to be purchased and that money is needed to buy them. They should be able to recognize different coins and know coin values, and should have basic counting skills. These skills are usually emerging by about the age of 5 or 6.

How Much Allowance is Enough, But Not Too Much?

"Enough so that your children can squander it, but not so much that you'll be upset when they do," advises Janet Bodnar, who also writes "Ask Dr. Tightwad," a column about kids and money that's syndicated by the *New York Times*. That is, the children should receive enough to make some meaningful decisions about what is important to them, but they shouldn't get more than they're comfortably able to manage. Research shows that, while children from higher-income families are more likely to receive an allowance, they don't receive a higher allowance than other children. *Youth Monitor*, a syndicated service of Nickelodeon and Yankelovich Clancy Shulman, surveyed students nationally about the allowance they received, and found the following 1996 average weekly allowances:

Age	Amount	Age	Amount
6 — 8	$ 2.77	14 — 15	$ 8.91
9 — 11	$ 3.72	16 — 17	$10.74
12 — 13	$ 7.08		

What Should the Allowance Cover?

That depends on the age and maturity of your children, the tasks you want to entrust to them, and the financial values you want to encourage. Young children can manage "budgeting" for toys or discretionary items, but children may need to be about 10 to 12 before they are ready to budget for a week of school lunches. Middle teens (15 or 16 and older) may be prepared to budget for their own clothes. And, if you want to instill the values of charitable giving and long-term saving for major items such as a car or a college education, your allowance structure and amount will need to take this into account. Make a list of your child's expected monthly expenses (including investments and donations), as well as sources of income (allowance, gifts, work for pay) to see if they're in sync.

Should Allowance Be Tied to Completion of Chores?

It is important for children to learn to *earn* money. After all, in the real world, work produces earnings. However, many parents feel that chores are the children's contribution to the maintenance of the family and home, and there should be no pay for these tasks. It seems less complicated and cleaner to keep allowance and chores separate. Differentiate between which jobs are not paid but rather are expected to be done to help the family, and which jobs may be done to earn extra money in addition to allowance. If chores are frequently not completed, and you're tempted to withhold allowance, or if you do tie allowance to chore completion, see below.

Should I Withhold Allowance as a Punishment?

This is likely to come up in one of three types of situations:

1. Your arrangement says that allowance is earned by completing chores, but your child didn't complete all the work. In this case, a pre-determined fee schedule would let you both know how much each chore is "worth." Some parents use an "all or nothing" arrangement: a child has to complete all chores to earn any allowance. In either situation, however, you can run into the problem of a child who decides that s/he doesn't need his or her allowance that week, and so declines to perform the work. (This is another argument for keeping chores and allowance separate.)
2. You're upset with your child's misbehavior unrelated to chores or to any monetary damage (example: staying out past curfew). You withhold allowance to try to impress on your child how much that behavior upsets you. In this case, withholding allowance will confuse the rules about your allowance arrangement and may seem unjust to your child. It's best to look for some other, more relevant, consequence for the behavior that will seem to fit the transgression. In the case of staying out past curfew, for example, the child might be grounded for a period of time.
3. Your child owes you money, possibly because he or she has borrowed money or has broken something that needs to be fixed or replaced. In these situations, it's best to pay the allowance according to your regular arrangements, and then have your child pay back whatever is owed to you. This works best for two reasons. First, when you pay the allowance, you're demonstrating *your* fiscal responsibility and sending the message that you can be trusted to keep your end of the deal. Second, when your child reimburses *you*, s/he is also practicing responsible behavior by paying the debt. It feels more real when actual money changes hands.

Resources

Your local bank. *Many banks have information on saving for kids, and officers who work specifically with children's finances. Or, contact Denver's Young Americans Bank at (303) 321-2265. The bank offers mail- in savings and checking accounts, credit cards and loans for children and teenagers.*

Bodnar, Janet (1997). *Dr. Tightwad's Money-Smart Kids.* Washington, D.C.: Kiplinger/Times Business. *Addresses a wide range of topics regarding children and money, including allowance, investing, collecting, jobs for teens and paying for college. Very interesting and fun to read, with loads of practical ideas and answers to parents' most commonly-asked questions.*

Godfrey, Neale (1991). *The Kids' Money Book.* New York: Scholastic, Inc. *This book is written for intermediate-age students, gives a history of money, and explains banking, credit and investing in terms that children (and adults) can understand.*

Zillions: Consumer Reports for Kids. Subscription Dept., P.O. Box 53029, Boulder, CO 80322; 800- 234-1645. *This magazine is the flashy and lively children's version of the popular* Consumer Reports *magazine. It provides information about products for children as well as articles on financial topics.*

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by John M. Hintze, Ph.D., NCSP
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Bedtime
Guidelines for Parents

Introduction

Difficulties getting their child to go and stay in bed is one of the most frequent problems parents of young children report. Indeed, after noncompliance, it is one of the most frequent problems presented to pediatricians and community health clinics, although many would consider this to be a form of noncompliance also.

Development

Almost all young children go through a period when they resist going to sleep. Theories as to why children refuse to go to bed are varied. The very young tend to have difficulties with the bedtime ritual due to "separation anxiety." The child is afraid that something may happen to his/her parents while asleep. Older children, ages 4 to 6, tend to have specific fears associated with going to sleep. They may be afraid of monsters, the dark, or having a bad dream, all quite normal concerns for children at this age. About one-third of the children ages 3 to 10 years have disturbing dreams. These peak at about age 10 and decline with age for both boys and girls.

Regardless of the reasons for which children resist going to bed, the manner in which parents handle the difficulty plays a considerable role in its short- and long-term outcome. Resistance on the part of the child can quickly become a learned behavior separate from fears and other hypothesized causes of the original problem. The strategies that children learn to postpone bedtime are many, and the bedtime ritual can take hours if parents allow themselves to be manipulated by the child. What starts out as genuine fear can quickly turn into a stubborn unwillingness to go to bed. Like many other forms of behavior, children learn that nagging, whining, crying, etc. can extend going to bed beyond the normal bedtime. Parents, because they are tired themselves, often do not have the emotional energy left at the end of a long day to follow through with established rules and may end up giving in to the child's demands. Although this relieves the parent's problem momentarily, what the child often learns is that begging for another story, asking for one more drink of water, another trip to the bathroom, whining, etc. will often put off going to bed. Once such a pattern has developed, it is very difficult to change.

What Can I Do as a Parent?

First, parents must decide if they have the time and energy to devote to changing the behaviors. Commitment is important since a half-hearted attempt and inconsistent implementation usually makes the problem worse. This happens because parents tell themselves that "this time we're not going to lose." The child, realizing that his old "bag of tricks" is not working, intensifies his effort and behavior. Although they may have "stood by their guns" for a number of days, circumstances arise that once again, and it is easier for parents to relax the rules and give in. What the child learns however, is that there is now a new threshold that they must attain before parents will give in. If this pattern continues, it leads to escalated battles between the parents and the child over going to bed. Again, consistency is of great importance and lasting change is unlikely without it.

Making a change. First, parents must set a regular bedtime routine with their children. A regular routine allows the child to be ready for sleep at the same time each night. The hour before bedtime should be a quiet and relaxed time for the child and parents alike. This is not a good time for overly stimulating activities and horseplay. Parents should start cueing the child that bedtime is approaching. Letting the child know that bedtime is in a half-hour or fifteen minutes gets him or her ready and provides a cue that the day is coming to an end. Adding something pleasurable to the warning, such as a snack, helps to get the ball rolling on a positive note. Suddenly telling the child that "it is time to go to bed" and rushing the child off only invites trouble.

Be firm and uncompromising. Make it clear that once the child is in bed and pleasantries exchanged (e.g., a story read, a kiss goodnight, etc.), this is the end of interactions for the day. If the child whines and objects, ignore it from behind closed doors. Entering into a discussion is just what the child wants since this has worked to delay going to bed in the past. The key is to establish a pre-bedtime routine that is pleasurable in and of itself and then to firmly enforce the need for the child to go to bed. If the child leaves her bedroom, return her to bed promptly, remembering not to be drawn into bartering with the child. Once again, consistency is the key to managing bedtime misbehavior. In most cases, changing the behavior will take as long as it took to set the behavior; but children will adapt to a different schedule in a manner that avoids strained relations and unpleasantness.

If problems persist: If your child continues to have difficulties handling bedtime routines or falling/staying asleep, you should consult your health care provider, school psychologist or school nurse for suggestions and possibly evaluation to rule out a serious sleep or behavior disorder. Persistent sleep difficulties can cause problems in performance at school or changes in behavior, such as inattentiveness and irritability. Usually, behavior change strategies are effective. It might be helpful to rule out a medical problem if your child has difficulty falling asleep or has unusual sleep patterns.

Resources

Huntley, R. (1991). *The sleep book for tired parents: Help for solving your child's sleep problems.* Seattle: Parenting Press. *A helpful guide to common sleep problems. Suggestions for family plans and resources.*

Lanksy, V. (1991). *Getting your child to sleep and back to sleep.* Deephaven, MN: Bookpeddlers. *Bedtime routines, fears, colic, etc. written from a parent's perspective.*

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Child Care and Day Care

Guidelines for Parents and Agencies

by Susan Vess, Ph.D., NCSP
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Introduction

Although generally referring to care provided to all children, the term *child care* frequently designates child care arrangements by someone other than the child's mother; while *day care* typically refers to out-of-home care. This distinction is useful because the various types of child care are frequently sorted by in-home versus out-of-home arrangements, including:

a) *in-home care* at the family's residence by sitters and extended family members

b) *out-of-home care* such as family day care in the provider's home, nursery schools and preschools, and center-based group day care located in churches, work sites and other places where child care may or may not be the primary business.

In American history, the provision of child care originally was a means of protecting or socializing children from poor or troubled families. Today, economic necessity, an increasing number of households headed by single parents, and changing roles of women have turned the norm of an employed father and an at-home mother into both a myth and a memory.

Most mothers, even with infants, are employed and consequently need child care. Unemployed parents also use child care. Some parents use child care to provide a break from the demands of child rearing or to give their children educational and social opportunities. Thus, access to affordable, quality day care for children has become a major issue for many American families.

Government surveys indicate that mothers of nearly 10 million children under age 5 years work. Of these children, 48% are cared for by relatives (17% by grandmothers; 16% by fathers; 9% by aunts, uncles or cousins; and 6% by mothers working at home). The remaining 52% are cared for by others, including child care providers working in their own homes (21%), staff of day care centers and nursery or preschools (30%), and non-relatives in other arrangements (1%).

Child care standards: Parents require child care options that allow them to work, attend school or job training, or seek employment without risking the safety and well-being of their children. Additionally, they need options that provide developmentally-appropriate educational and social opportunities for their children, not simply temporary custody.

Despite on-going discussions and repeated attempts to set a national policy for provision of child care, there are no national regulations that guarantee accessible, affordable, quality child care to all American families. However, the states and various organizations have established standards, even though these are often inconsistent. The Panel on Child Care Policy identified three policy goals for the provision of child care:

1) quality out-of -home care in terms of both services and arrangements
2) accessibility to quality child care by families in every social, economic and cultural circumstances
3) affordability of child care for low and moderate income families

These three goals capture the central concerns about the provision of child care in the United States: quality, accessibility and affordability. Affordability and quality are often linked. Accessibility may relate to these factors and to logistical considerations such as parental work schedule.

A variety of factors, including mixed feelings about changing roles of women, maternal education and employment, as well as ambivalence about the value of children, contribute to the lack of consistent policies and regulation of child care. The traditional American belief that child rearing is a private family matter, except when the safety of a child is at stake, also limits government involvement in child care. Finally, pressures to tighten eligibility criteria for economic assistance to the poor, the inadequacy of tax credits to cover the cost of child care, and on-going efforts to reduce government support of domestic programs makes it increasingly difficult to find adequate child care services. Although many situations do not meet suggested standards for child care, parents typically report satisfaction with their current child care arrangement, irrespective of type.

Child Care and Child Development

Findings from the earliest research failed to support fears that child care had an inherently negative impact on child development. It is now recognized that both positive and negative consequences for children are associated with every type of child care, from at-home care by mother to for-profit center-based, group care. It is *quality* of the child care, not type or provider, that is the critical factor in children's development. Further, it is also very difficult to tease out the separate and relative impact of child care and family dynamics on children's development . Finally, family and child care are intertwined, with three possible outcomes:

a) family and child care support each other in raising children, enhancing child development;

b) family or child care compensates for the limitations of the other;

c) family and child care are both detrimental, complicating the child's social, cognitive and behavioral development.

Child Care Characteristics

Ethnic differences: There is diversity in the types of child care arrangements chosen by parents. White families use child care more than Black or Hispanic families. Moderate, rather than low, income families are also more frequent users of child care. Mothers who have their first child after age 25 years and/or have four or more years of higher education are more likely to work than younger or less educated women. Women now continue working rather than leave after bearing children. About half of employed Hispanic and Black mothers more often rely on relatives than do White mothers (20%). 32% of Black and White parents place there children in organized child care as compared to 21% of Hispanic mothers.

Multiple children, different ages: Child care arrangements are especially complicated when parents must find care for several children of various ages. In-home options are often preferred when there are multiple or young children involved. Children typically move from in-home care to preschools or day care centers after they are reach three years of age. Child care centers are increasingly popular options, particularly as income levels rise.

Parents' schedules: In-home care provided by fathers and extended family members is often related to parents' shift work and schedules. For example, young children are cared for by relatives (35%) or fathers (24%) when their mothers work a non-day shift as compared to 29% by relatives and 11% by fathers when their mothers work the day shift. Young children are more likely to be cared for by a non-relative or at a center when their mothers work the day shift.

Economic differences: More poor children (60-70%), especially those of single mothers or parents who are part-time workers, are cared for by extended family members than are middle class children. Family members are compensated for child care services by cash payment or by exchange of services. Poor families face special difficulties in arranging suitable child care, including fewer overall choices and special difficulty finding a child care provider who shares the family's ethnicity, language, culture and traditions.

Child Care Suggestions

Overall, there is a huge array of options in providers, group size and child-staff ratios, sponsorship, type of programming, etc.; but the full range of choices, especially in terms of quality, accessibility and affordability, is not available to all families. Whether parents exercise their child care preferences depends on many factors including the number, quality and cost of the various options available to them, as well as the human and financial assets of the family, logistics (distance and hours) and attitude toward maternal employment and child rearing values. Families suffering from financial and psychological stresses may lack the necessary resources to select quality child care, putting their children in additional jeopardy of adverse developmental outcomes.

Parents initially assess family resources, attitudes and constraints when considering their child care options. They then identify realistic options by asking their informal network of friends, neighbors and family members for suggestions. Usually, parents contact child care resources and community agencies only when they have exhausted their personal contacts without finding a suitable arrangement. When selecting a child care arrangement, parents must consider two critical issues:

1) child care produces both short-term and long-term consequences for children

2) child care should be safe, fun and educational

Quality child care is associated with three factors: (1) maximum group sizes for children of different ages, (2) caregiver-to-child ratios, and (3) caregiver training:

Group size has important consequences for child development, although it is rarely regulated. The Panel on Child Care Policy recommended the following group sizes:

- up to 1 year, between 6 and 8 per group
- 1 to 2 years, between 6 and 12 per group
- 3-year-olds, between 14 and 20 per group
- 4- and 5-year-olds, between 16 and 20 per group

Child-staff ratios are important, especially for infants and toddlers, although there are variations in permissible/acceptable ratios from place to place. Infants attach to several care takers with whom they have an ongoing, dependable relationships. The Panel on Child Care Policy set the following child-staff ratios:

- first two years, not higher than 1:4
- 2-year-olds, 1:3 to 1:6
- 3-year-olds, 1:5 to 1:10
- 4- and 5-year olds, 1:7 to 1: 10

Training of child care workers, especially in child development, contributes to quality programming. Child care workers with the sufficient type and amount of education are more likely to organize activities that are child-directed, fun and developmentally appropriate as opposed to teacher-directed, schoolish lessons. Child care arrangements in which staff has access to organized, equipped, diversified space that permits a variety of child-centered activities and child-driven choices are also related to quality.

Health Risks: Children raised at home do not differ from children in child care by types of illnesses and injuries sustained, although children in child care tend to experience more mild childhood illnesses. With the possible exception of upper respiratory infections leading to inner ear infections and their potential impact on children's speech and language, children in child care do not suffer long-term or serious consequences to their health status. Nevertheless, there are suggestions for reducing the health risk to children in child care, including limiting group sizes; organizing children by age; washing hands, especially at times of eating and toileting; disinfecting surfaces and toys; and monitoring for and responding to rare outbreaks of serious infectious such as hepatitis or meningitis.

Parent Involvement: Finally, parents should ensure quality child care for their children by becoming actively involved in whatever arrangement they choose. Initially, parents should thoroughly investigate all child care options before enrolling their children. Later, they should monitor their children's experience in child care by spending time at the site with their children, making surprise visits, providing an easily accessible contact in case of emergency, and asking their children about their experiences and satisfaction with the current child care arrangements.

Resources for Parents and Professionals

Casper, L. M. (1997). *Who's minding our preschoolers?: Current population reports,* ED395670. Washington, DC: U. S. Government Census Bureau. <lcasper@census.gov> *This resource provides information about child care statistics and resources on the internet. Response to inquiries is rapid and varied.*

Dalley, M. B., & Vess, S. M. (1987). Children and childcare. In A. Thomas and J. Grimes (Eds.), *Children's needs: Psychological perspectives* (pp. 87-95). Washington, DC: National Association of School Psychologists.

Hayes, C. D., Palmer, J. L., & Zaslow, M. J. (Eds.). (1990). *Who cares for America's children: Child Care Policy for the 1990s.* Washington, DC: National Academy Press. *This book talks about the history and issues surrounding child care in the U. S. It discusses various aspects of child care including: quality indicators, research, and impact on child development.*

Mitchell, A., Cooperstein, E., & Larner, M. (1992). *Child care choices, consumer education, and low income families.* NY: National Center for Children in Poverty. *This resource describes child care and differences in choices due to ethnicity and economic considerations.*

Phillips, N. (1994) *Choosing schools and child care options: Answering parents questions.* ERIC Document Services, ED374910. *This resource provides parents with information needed to make choices about their children's care, including evaluation potential options.*

Vandell, D.L., Pierce, K., & Stright, A. (1997). Child care. In G. Bear, K. Minke, and A. Thomas (Eds.), *Children's needs II: Development, problems and alternatives* (pp. 575-584). Washington, DC: National Association of School Psychologists. *This chapter discusses child care and its relationship to child development, including types of child care, family variables and issues and research on various aspects of child care.*

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Computers and Children

A Guide for Parents

**by William Pfohl, Psy.D., NCSP and Shawna Ferstl,
Western Kentucky University**

Background

In this new age of technology, many aspects of our daily lives involve using personal computers. Some adults have a fear of computers because they don't understand how computers work. This fear may be the biggest reason why people hold back from accessing the unlimited world of information that computers offer. Due to technological advances, early exposure and "lack of fear," most children are not intimidated by computers. Today's children are likely to grow up playing computer games (such as Sega and Nintendo) or be exposed to computers within their school curriculum.

Computers Can Promote Children's Development

With increasing media focus on possible harmful side effects of using computers, it is difficult for parents to know what is best for their child. Despite the negative media, research has shown that computers offer numerous advantages to children when used properly and under adult supervision. Computers can:

- enhance children's development of cognitive and language skills
- aid in the development of eye-hand coordination in preschoolers
- enhance development of reasoning, logical thinking skills and problem solving strategies
- allow children to learn through a variety of senses
- provide an array of information sources such as multimedia enhancements and interactive software
- stimulate children's curiosity and creativity
- permit children to work at their own rate, reducing peer pressure to speed through activities without mastering concepts being taught
- help children with academic problem areas through drill and practice software
- make learning both entertaining and enjoyable for the child with the large video monitors, CD-ROMS and sound cards found with today's computers

Parents who want to build their child's **self-confidence** can ask their child to explain the computer, its programs, and games. It does wonders for the child to think he/she knows more than the parent. Also, if more than one individual in the family uses the computer, the child learns **social skills** such as waiting to take turns and respecting others' property (e.g., files, disks, etc.).

Disadvantages of Computers

Although computers have many advantages for children and adults, parents do need to be aware of some of the disadvantages. One significant disadvantage is when the computer becomes a baby-sitter. Parental involvement while the child learns about and uses the computer is essential. Quality family time should not be replaced by numerous hours of sitting in front of a computer monitor (or TV for that matter). Children still need to get outdoors and engage in physical exercise in order to stay healthy. Also, research is presently being conducted to find out if too much electromagnetic radiation from long term exposure to computers can be a health hazard. Keep alert to these upcoming findings. However, of all the disadvantages listed thus far, probably the most unfortunate one is that a computer may not fit into the family's budget. If this is the case, check for services available in your area (such as your local library or public schools) where computers may be accessible to the family.

What Computer Should You Buy?

Two basic types are available, either an IBM/compatible or Macintosh. Your child may have used one type at school and liked it, or you may use one type at work. Macintosh is superior in graphics and ease of use. IBM/compatibles have a wider range of software and have greatly improved graphics recently. You need to buy as much computer as you can afford, as the technology is changing every eighteen to twenty-four months. Shopping for a computer for your family can be confusing. For your first computer purchase, you might find it helpful to attend a community education class or a class offered by one of the local computer stores. Many communities also have "computer user groups" which can offer advice. There are also many publications — books and magazines — which provide basic comparative information. Finally, consider consulting computer instructors at local colleges and public schools, as well as knowledgeable friends.

Basic Computer Skills for Children

Prior to working with the computer, your child may need to be taught some basic computer literacy skills. The computer components (mouse, keyboard, monitor, CD-ROM, etc.) should be explained to the child, using basic, simple definitions and explanations that the child can understand. Many of the new computers have demonstration programs to help beginners learn how to use these different components. Once the computer components have been explained, start practicing with the keyboard and the mouse. Most software is in the Windows type format and requires use of a mouse to move around the programs. Young children should begin to learn how to manipulate the mouse by "clicking and dragging" objects on the screen. Older school-aged children, who already know how to manipulate the mouse, can start off practicing with the keyboard and its different components. While children should be taught to respect the computer as they would any other expensive and sensitive equipment, with young children around, some parents may want to cover the front panel of the computer to decrease the child's temptation to stick things (pencils, toys, etc.) in the CD-ROM and disk drives.

Software and Online Material for Children

Building a well-rounded library of software can be a great way to keep children interested and motivated to learn about a wide range of things. Software needs to be easy to use and should teach specific skills; these are typically listed on the box. Remember, violent software may have negative effects on your child, as does violent TV. Supply your child with his/her own brightly colored or personalized disks. Also, parents can use a password to limit children's access to the files, the command prompt (C:\), and file directories that you wish to keep the child away from. Children should be taught to respect others' programs, as computers are often community property.

Online services: Parents are hearing more about the potentially negative effects of online services (America OnLine, Prodigy , etc.) or Internet. The Internet Highway can offer many exciting opportunities, if monitored and supervised properly. However, parents need to be aware that some inappropriate information is available to children online. Parents may want to supervise their children while they are online and tell their children that they should not give personal information about themselves to *anyone* online. They also should be reminded not to fill in any "forms" online for free materials or to sign-up for activities without strict parent supervision.

Set Guidelines for Computer Use

Before introducing your child to the world available through computers, parents need to develop guidelines to assure their children's safe and enjoyable computer usage:

- Establish rules and boundaries so the child knows when and how to use the computer
- Give your child support and encouragement — help the child become comfortable with the computer through basic computer skills (see above)
- Teach your child that mistakes are okay
- Teach your child to stop and ask an adult for help if a problem occurs with the computer or program
- As noted above, using online services has many pitfalls and families should establish strict rules regarding access to such programs and provide supervision
- Gather information regularly about computers through discussions with friends, subscribing to children's or family-focused computer magazines or attending computer-user group meetings

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Computer Software for Children

Guidelines for Parents

by William Pfohl, Psy.D., NCSP and Shawna Ferstl
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Before You Shop

Before heading to the store to buy some computer software for yourself or your children, there are a few important things you will need to know. First of all, you need to make a list of your computer specifications (e.g. make, model, hard disk capacity). If you do not know, bring the owner's manual and packing slip/invoice with you. Not all software will work on all computers! Many stores will not take back opened software packages, so be sure it will work before you leave the store. The specific characteristics of your particular computer and its disk operating system (e.g. MSDOS/PCDOS, Windows 3.1/3.11, Windows 95, MAC) will help you determine which software programs will be compatible with your specific computer.

Computer Specifications

The following is a list of your computer specifications, which you will need to know before you buy software:

1. Type and speed of your processor — such as type — Pentium, 486; speed 66 to 200 MHZ).
2. Amount of memory installed — amount of RAM memory you have. Most have 4 to 8 megs, with 16 megs being recommended for Windows 95.
3. Space available on hard disk — most today have 850 megs or higher; multimedia software will require ***large*** amounts of space — higher is typically better.
4. Type of sound card with speakers — *Sound Blaster* compatible is the most universal standard. Make sure the software works with your specific sound card. This is an area of technology where many problems still exist and can create a very frustrated parent and child.
5. CD-ROM Driver — they come in speeds marked in X (2X, 4X or higher). Also called "double or quad" speed. The "throughput" or *transfer speed* will be in your owner's manual. (Most CD-ROMS are simple to add to your system, if compatible with the sound card.)
6. Video standard supported by video card and monitor — VGA, SVGA are typical standards. The software needs to match your monitor's capability, such as amount of colors available or Windows compatible.
7. Modem speed — typically "28.8" or faster is now the standard. This is the speed at which information is transferred to other computers or on-line services.
8. Printers — if you purchase a printer, most software comes with the necessary printer driver for that software.

Hardware Requirements

Make sure that your software will work with your disk operating system (such as MAC, MSDOS/PCDOS, Windows 3.1/3.11, or Windows 95). When you find a software package at the store, check the hardware requirements. Make sure the software can run on your specific type of computer, typically IBM/compatible or Macintosh. Some new software will run on both, particularly CD-ROM. The hardware requirements are usually listed on the software box in small print. You will want to compare these requirements to the list of your computer specifications. The specifications listed are a minimum. If your computer system either matches these specifications or is higher level, the software program should be compatible. If in doubt, ASK! Also, if using Windows 95, ask if it is Windows 95 compatible, if the box does not say. Some small companies may not do extensive testing. Check to see if there is technical support offered and if it is toll free or toll call. Sometimes there can be delays getting in touch with technical support staff. (Most of us have needed to call for help in setting up and using software, so do not hesitate or feel dumb about asking.)

Developmental Issues

The age level and skill level needed for the software program are printed on most software boxes . You will want to look for skill levels and challenges suited for the different ability levels of your children. The published ranges are fairly accurate in today's software, with many being extensively field tested before sale. Children's developmental levels can be grouped into 3 different age groups:

Preschoolers: The first group would include most 3 to 5 year olds. During these ages, children develop cognitive and language skills, classification and sorting skills, and eye-hand coordination. While searching for software suitable for this age group and skill level, programs that involve memory tasks, classification tasks, alphabet tasks and eye-hand coordination tasks would be appropriate. The software should be active, colorful, easy to use and teach appropriate skills.

Early elementary: The second age group includes most 6 to 8 year olds. In this stage of the child's development, the basic cognitive and language skills already exist. The child is developing automaticity (quick recall and ease of learning), reading, writing and editing skills, problem solving, reasoning, and logic skills. Software suitable for this age group and skill level will include tasks that require reasoning skills and language activities. The software needs to be engaging, easy to learn, have the child read or manipulate information and be challenging without being frustrating.

Older Elementary: The third age group includes ages 9 to 12 years. This is the stage of development when children begin to use higher thinking skills, learn to synthesize information, develop an understanding of abstract concepts and develop advanced problem solving skills. Software for these ages and skill levels may involve more challenging activities that interest the child. Multimedia using sound, high resolution graphics and action makes learning fun.

Getting Advice

When buying software for your children , take your child along to the store and ask him/her what interests them. You may save a lot of money on un-used software, and the child also feels important being a part of the decision process. Software can be purchased from schools, software stores, and mail order. When first buying software, find a store and staff that can give you specific advice and will help you if there are problems. The software should have a technical support line either by phone or modem. Many magazines (e.g. *Family Computing, HomePC*) that are family focused publish critiques of software. Ask your child's teacher what software is being used at school. Go to Computer Users Groups too. The times are usually posted in the local newspaper or library. Doing your homework before you buy will prevent difficulties later.

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Divorce and Children

A Handout for Parents and Teachers

by Louise K. Eckman, Ph.D.
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Overview

This year about one million children will experience a family divorce. About 50% of marriages end in divorce, which means that more than one-third of the children will live in a single parent household for part of their childhood. Divorce is distressing for children, but the majority of children adjust to this change in their family in a year or two. About 60% of children have no contact with their fathers after divorce. Many children, however, have regular visits to the parent with whom they do not live, and these visits are extremely important to a positive divorce adjustment. Divorce is increasingly being seen as a difficult experience on the path to growth, rather than a tragedy from which there is no recovery.

Adjustment to Divorce

The effects of divorce vary from one family to the next. Initially, children may experience anger, depression, social withdrawal, guilt or lower school performance. Some children begin to accept the change in their family in the weeks and months following the separation, while others may experience years of sadness, anxiety or acting out. The child's adjustment to divorce is dependent on many factors — the child's age, relationship with each parent, prior adjustment and ability all play into divorce adjustment. Other related factors such as geographic moves necessitated by divorce and loss of contact with grandparents or other relatives may impede the child's divorce adjustment.

The younger child's adjustment to divorce is closely related to parents' adjustment. For teens, however, family disruption due to divorce may make these naturally turbulent years even more difficult. Boys are usually more negatively affected by divorce than girls. Psychological research shows that boys in single-parent homes may develop relationships with their mothers marked by non-compliant, anti-social behavior. On the positive side, youth in single-parent homes often have more responsibility than youth in intact homes.

What Can I Do as a Teacher?

1. ***Be sensitive to students' emotional states:*** If a student seems distressed over a period of weeks, or if schoolwork declines, a referral to the school psychologist may be helpful.
2. ***Listen to students' concerns:*** Often, children will confide in some trusted adult outside of their family when divorce occurs. It is helpful to listen to students' concerns and to let them know you are available to them.
3. ***Encourage support groups:*** Divorce adjustment groups can be helpful for students. If your building does not have one, talk to your school psychologist, social worker or counselor about starting a group for children impacted by divorce or parent separation.

What Can I Do as a Parent?

1. ***Reassure and support:*** Reassure your child that both parents still love him/her and want to take care of him/her, and that he/she did not cause the divorce.
2. ***Be available to your child:*** Try not to decrease the amount of time you are spending with him/her.

3. ***Don't expect your child to share all of his/her feelings about divorce:*** Your child may be apprehensive about letting you know that he misses his/her absent parent.
4. ***Provide consistency:*** Do maintain continuity as much as possible in the child's activities and relationships.
5. ***Plan enjoyable outings.***
6. ***Don't criticize*** the absent parent, or share adult concerns about financial problems or conflict areas. Get adult support if you need it. A counselor, school psychologist, or family psychologist can help you adjust, handle strong emotions and evaluate difficult decisions.

Child Custody Arrangements

Joint custody is thought to be the most beneficial custody arrangement according to social science researchers. Joint custody means that both parents play a role in the upbringing of the children. It does not mean that the children take turns living with each parent. It is important to support the parental efforts of both parents and to encourage them to continue their involvement in parenting. It is equally important for parents to learn to reduce conflict and improve communication skills. Usually, children find their parents' marital conflict quite distressing and are relieved when they begin to relate more constructively to each other.

Remarriage and Step-families

Often the first year after a marital separation is filled with turmoil, upsets and new adjustments for all involved. Mothers may begin working, or working longer hours, which may be experienced by children as a loss. Children will need plenty of sympathetic support during this time. Social scientists have found that social support can facilitate good divorce adjustment. Relationships with friends, teachers, school psychologists and organizations such as churches and temples, Scouts and clubs can also be very important.

Not long after the turmoil of separation begins to subside, one or both parents may find new relationships, and another hard adjustment for the child begins. A child's adjustment is easier in a "simple step-family" in which the new parent does not have children of his/her own to bring to the relationship. In "complex or blended step-families", both adults bring children into the new family, and adjustment will be slower and more difficult for the child. It is especially difficult for a child to accept the arrival of a new child into the step-family. Research shows that such children are more likely to experience adjustment problems.

In many step-families, great effort is made to facilitate a good adjustment for all, and boys seem particularly to improve their adjustment by gaining a step-parent. According to the Step-family Association of America, Inc., the step-family adjustment takes about five years. The first year or two is often filled with discomfort, conflicting loyalties, and "left out" feelings. As family members work to reduce rivalries and parents improve their parenting skills, the family moves toward more harmonious, supportive relationships.

Resources

Rogers, F. (1996). *Let's talk about it: Divorce.* G.P. Putnam & Sons.

Lansky, V. (1996) *Divorce book for parents.* Book Peddlers.

Berman, C. (1986). *Making it as a step-parent.* Harper & Row.

Boulden, J. & J. (N.D.). *Early separation and divorce activity books.* Boulden Publishing.

National
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Foster Homes

A Handout for Teachers

by Nancy A. McKellar, Ph.D., NCSP
Wichita State University

Background

Children in foster care have been removed from their biological home to protect them and to improve their well-being. The Federal Adoption Assistance and Child Welfare Act of 1980 (PL 96-272) requires permanency planning within specified time limits to prevent children from languishing in foster care without a goal being set for either reunification with the biological family, adoption, guardianship, or long-term foster care until emancipation.

Since the mid-1980s, the number of children in foster care has risen dramatically, with disproportionate increases among young children and in large, urban areas. More and more of the families from which children are removed have complex multiple problems. The impact has been an increase in the foster care population due to many drug-dependent infants entering the system at birth and additional young children entering as victims of abuse and neglect by their biological parent(s) who are abusing drugs. Poor minority children enter the foster care system at a higher rate and younger age than other children.

Two variations of foster care that are expected to expand in the future are kinship care and specialized/treatment/therapeutic care. Foster care by members of the child's extended biological family is called kinship care. Children in kinship care tend to have more contact with their biological parents, have a much lower probability of multiple placements, and remain in the same school and neighborhood after entering care. Specialized foster care is designed for children with extreme behavior problems or with complex medical needs, such as HIV infection. Usually foster parents providing this type of care receive more training and significantly more compensation, and are more involved in the case planning for the child.

Development

Separation from one's biological parent(s) represents a significant loss for the foster child. But the loss is more pervasive than just losing one's parent(s) because the child usually loses siblings, grandparents, pets and belongings when placed in foster care. The shock, anger, despair and acceptance that comprise the grieving process are experienced by foster children as they mourn the loss of their biological home. Feeling psychologically vulnerable is the primary effect of being removed from one's biological parent(s). Foster children may experience confusion, anger, alienation, and ambivalence. They may withdraw and isolate themselves, test rules excessively, engage in wishful and magical thinking, be dependent and passive, and/or have limited self-confidence.

The experiences of children in foster homes are affected by the length of time they have been in foster care and the age at which they were first removed from the biological home. For many children, foster care results in long-term instability. Most children who leave foster care do so by being reunited with their biological families. The more frequent the visitation between the child and biological family members, the greater likelihood that the child will be reunited rather than continue in foster care.

Attachment and separation are the dominant psychological issues in describing how children at different developmental levels react to removal from the biological parent(s) and how they adapt to foster care. Very young children may exhibit developmental delays, clingy and dependent behavior, temper tantrums, and withdrawal. Children who enter foster care as preschoolers may see themselves as deserving of prior abuse, fear continual hurt, have poor impulse control, and find it difficult to separate from their foster parents. Elementary-aged foster children have difficulty listening and following rules, may be fearful and anxious, think often of family problems, have poor frustration tolerance, and fail to complete work. Adolescents often struggle with authority figures; experience conflicting loyalties between their biological and foster families; feel inferior, "different," or worthless; and become anxious over their approaching emancipation.

The lives of foster children are characterized by many situational changes. While they are with their biological families between birth and placement, their families are characterized by divorce, separation and widowhood. The most common reason that they are moved from home to home, once they are in the state's custody, is that they run away and/or have behavior problems. Children who have experienced several out-of-home placements may feel like they have no control over their lives, leading to learned helplessness behaviors. The more life situation changes experienced, the more likely the child will be hostile and oppositional.

Foster children may go for long periods of time without information about or contact with their biological families. They may worry about their siblings who remain in the biological home or have gone into other foster homes. When children are not informed about decisions and plans regarding their future, they fill the void with fantasies of their own.

Foster children experience higher rates of poor school achievement and emotional and physical disabilities. Also, there is a disproportionate number of foster children in special education. The most common handicapping conditions among foster children are learning disabilities, mental retardation, and emotional disturbance. Behavior problems are found more frequently in foster children than their age-mates. Conduct disorder is the most prevalent single disorder.

Foster children often do poorly in unstructured activities, such as recess. Their tendency to be easily victimized or start fights can result in peers treating them as their biological parents did and reinforcing their belief that they are bad and deserving of abuse. They may test the limits of authority, have angry outbursts when asked to do something, or avoid contact with authority figures. Truancy and school refusal are common among foster children. Teachers noted particularly poor attention and work study habits.

What Can I Do as a Teacher?

- The school should establish and maintain a good relationship with the foster parents to facilitate their involvement in the child's education. Any intervention involving home-school contingencies requires full cooperation of the foster parents. They need to support the child in completing homework assignments. The extent, timing, and type of involvement of the biological parents in the child's education should be discussed by the school team and the child's case manager.
- Children who start school prior to foster care placement may have a history of inadequate instruction. The biological parents may have moved often, not consistently gotten the child to school, not provided important home and community experiences that are common to other children, and failed to support the child in completing homework assignments. Placement in foster care may have required that the child change schools. Error and task analyses will help to identify curriculum content that the foster child has missed.
- The school nurse should be asked to assess whether the child appears to have unmet or undetected health needs. Health records may be very limited. Foster children are at risk for discontinuous and inadequate medical care, poor health and nutrition, and very low weight and height.
- The foster child's rights to confidentiality and privacy may result in less background information than the school team typically has for assessment and intervention services. However, the teacher should ask the foster parents about any special needs, problems, or interests the child has.
- Every effort should be made to help the child develop a relationship with at least one other person who really cares about the child, can affirm the child's worth, and can be a good listener for the child's concerns and conflicts. This person might be yourself, a relative, foster parent, counselor, or teacher aide.

- Many foster children have good interpersonal skills and are eager for approval and affection. Interventions that capitalize on such characteristics, like cooperative learning and positive reinforcement, should be sought.
- Special attention should be given to the child management approaches used with foster children who have experienced abuse and/or neglect. Interventions helpful for abused children include behavior management, self-management. and natural consequences. Neglected children are quite emotionally needy. They benefit from a structured, predictable environment coupled with much individual attention. For both groups of children the environment needs to have clear limits and consequences that are consistently enforced. Ignoring inappropriate behavior should be avoided because these children often increase the behavior being ignored to dangerous levels. However, punishment of any type, particularly corporal punishment, should not be used with foster children. A consideration needs to be made as to whether the child should receive counseling at school.
- Children with a history of multiple placements may be overly concerned with how the classroom works, instead of what is being taught. Teachers can make the classroom more predictable for these children by giving them such aids as schedules and advance organizers.
- Foster children whose biological homes were chaotic need more structure than their classmates. Teachers need to monitor the completion of assignments and work with the foster parents to make sure that homework is completed. The child's anxiety level should be reduced if the foster parents structure after-school time for homework, snacks, play and television.
- Interventions should be planned to address the child's hostility. Giving children a quiet place in the classroom to use when they cannot cope provides an alternative to aggression.

Resources

Bauer, A.M. (1993). Children and youth in foster care. *Intervention in School and Clinic, 28*(3), 134-142. *Specific recommendations are given to teachers who have students in foster care.*

Jewett, C.L. (1982). *Helping children cope with separation and loss.* Harvard, MA: Harvard Common Press. *Techniques and guidelines are discussed for helping children cope with grief over loss, which for foster children includes loss of the biological family and/or previous foster families.*

McKellar, N. (1997). Foster Homes. In G. Bear, K. Minke, & A. Thomas (Eds.), *Children's needs II: Development, problems and alternatives* (pp. 697-706). Bethesda, MD: National Association of School Psychologists.

Stahl, P.M. (1990). *Children on consignment: A handbook for parenting foster children and their special needs.* Lexington, MA: D.C. Heath. *This book's practical information on parenting foster children can be adapted for interventions in schools.*

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Homeless Children

A Handout for Teachers

by Diana Hensley
Newport Beach, CA

Background

Schooling for their children is often not the first priority for homeless families; rather, it is shelter, food and safety needs. Likewise, homeless children coming in — and moving again soon — often disrupt the classroom and present a variety of needs. It is important, however, to keep each child in school. This gives the child a chance to have hope for his or her future. The longer the child can stay in school, especially in the *same* school, the better his or her chance to get an education and learn life skills.

Educator's (and parent's) responsibility — to help keep the child in school: There is a federal law (Stewart B. McKinney Homeless Assistance Act as amended 1990) that gives parents the right to keep their children in the school s/he attended when they first lost their home. They also have the right to enroll their children in a school within the new area where they are now living. Children can also attend school the same day they enroll. Note that the *only* reason children may not be allowed to enroll right away is if they have not been immunized.

Needs of Homeless Children

Parents and children who have lost their homes are usually anxious and overwhelmed. Parents may come in to register for school and run the gamut from being cooperative to easily defensive. Sometimes the parents are ashamed or afraid and do not report that they are homeless. The address given may be incorrect because they are living in a van or staying temporarily with a friend. Homeless children have many of the same needs and problems as do children living in poverty who are not homeless:

Health: Health risks for homeless children can begin before birth, as mothers who are homeless have a much higher rate of prenatal complications due to poor nutrition and medical care. Their babies are more likely to have low birthweight and high lead levels; early pediatric care is likely to be sporadic. Homeless children are also likely to experience poor nutrition and related health complications (including obesity). Frequent relocation can reduce or delay AFDC and other welfare benefits that could support families with limited resources for food. Poor living conditions and crowding in homeless shelters place children at high risk for a variety of communicable diseases and asthma.

Emotional/behavioral problems: Homeless children have higher than normal rates of depression, anxiety and aggressive behaviors, and girls seem to experience more negative emotional consequences than boys. Children's social development is significantly impacted by homelessness, as frequent moves and lack of a real home interfere with the development of friendships and trusting relationships with both peers and adults. Research as to the long-term effects of homlessness is not conclusive; there is some evidence that emotional and behavioral problems associated with homelessness might not necessarily resolve once permanent housing is obtained. Low self-esteem, anxiety and poor social relationships may be ongoing problems for children who at some time experience homelessness.

Developmental delays: While homeless children appear to experience delays in most areas of development (cognitive, language, reading, motor skills), their level of risk appears to be the same as other poor children who have homes. The crowding of shelters, lack of learning materials and limited interactions with age-mates also appears to interfere with many aspects of development for homeless children.

Achievement problems: Homeless children, particularly those who are not living in shelters, experience significant problems learning basic skills. Frequent changes in schools due to moves, limited learning experiences outside of school, poor attendance and lack of continuity in instruction hinder their achievement. While homeless children by law are entitled to an education, their frequent moves make it difficult to obtain records and schools often must "start over" to determine eligibility for special education.

What Can the School Do To Help?

- ***Write your state department of education*** and ask if they have any brochures or handouts to give parents. For example, California's State Department of Education, Office of the Coordinator, Homeless Children/Youth Education Program, P O Box 944272, Sacramento CA 94244-2720, will send, upon request, brochures for school personnel and parents.
- ***Find out what county resources are available*** for homeless children. Connect families with these resources.
- ***Make a list of local resources*** and agencies, such as shelters, motels and charitable organizations that will help with medical, school supplies, etc. Often churches and temples have outreach programs and can provide school supplies, new socks and shoes. Teacher's educational groups and other organizations, such as Soroptomists, Rotary, etc., will help when given specific needs.
- ***Provide support:*** If possible, schools can make available a support staff professional to teach incoming students how to adjust successfully to the school setting — listening, social skills, self-esteem, how to ask for help, how to use the library, etc. This training should be provided by an adult, but an older buddy system can also be useful. Homeless children need a lot of support.
- ***Find a mentor:*** Local universities or high schools often have students who can help a homeless child as an on-campus mentor. Obtain parent permission.
- ***Make sure lunch (and often breakfast) programs are available***. Sometimes the parents need support in signing up for these programs.
- ***Help child with routines and structure.*** Sometimes they need help in doing homework.
- ***Support child on special occasions:*** If a child has a birthday, find out if the family needs a cake. It is better to give the family the cake so they can present it to the child.
- ***If children are moving away***, help them say goodbye. Give them a packet with their records and notes from the class.
- ***Work with your community to establish community-based and school-linked services*** for homeless families. Bringing community health and mental health services into the schools, and setting up educational and recreational opportunities in the community will help address the multiple needs of homeless families and their children.

While help should not replace or prevent self sufficiency, it is critical to support homeless children so they can learn the skills that lead to independence. Homeless children need to feel as if they belong, are valued, can do the work, can learn and that they are safe. When the anxiety goes down, the learning goes up.

Resources

Ford, L. & Cantrell, C. (1997). Homelessness. In G. Bear, K. Minke, & A. Thomas (Eds.), *Children's needs II: Development, problems and alternatives* (pp.689-695). Bethesda, MD; National Association of School Psychologists.

Kozol, J. (1988). *Rachel and her children: Homeless families in America.* New York: Fawcett Columbine.

Massachusetts State Department of Education (1991). *Faces of homelessness: A teacher's guide.* Quincy, MA: Author. (Guide and videotape)

United States Department of Education. (1992, September). *Serving Homeless Children — The Responsibilities of Educators.* Washington DC: Author. (USDOE, Washington, DC 20202-6132).

Organizations

District of Columbia Public Schools, Division of Special Programs and Alternative Education, Homeless Children and Youth Technical Assistance Branch (HCYTA), 6th and Brentwood Parkway, N.E., Washington D.C. 20002, (202)727-5559.

California Department of Education, Office of the Coordinator, Homeless Children/Youth Education Program, P.O. Box 944272, Sacramento CA 94244-2720; (916)657-5235.

U.S Department of Education, Education Projects Funded Under the Homeless Children and Youth Exemplary Grant Program of the Stewart B. McKinney Homeless Assistance Act. (P.L. 100-77).

Children's Defense Fund, 122 C Street, NW, Washington DC 20001; (202) 628-8787-5300.

National Association of State Coordinators for the Education of Homeless Children and Youth; Louisiana State Dept. of Education; 654 Main Street, 3rd Floor; Baton Rouge, LA 70801; (504) 2654-2371.

Some of this material is adapted from Ford and Cantrell (1997) — see resources above.

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Household Chores for Children

Guidelines for Parents

by Fred Provenzano, Ph.D., NCSP
University of Washington, Seattle

Background

Even though a vast majority of parents in the United States require their children to perform some chores, you might ask, "Why bother?". It sometimes seems that it takes more time and effort to supervise children through the chore than it would take to do it yourself. However, accomplishment of household chores can play a very important role in your children's development. First and most obvious, chores teach children basic skills for living, such as cooking, cleaning, laundry, etc. Second, they help to develop well-trained and efficient helpers over time. Third, they help children to develop basic work attitudes and habits such as reliability, responsibility, thoroughness, and persistence. These skills are generalizable to school and later paid employment, and are the building blocks for success as an adult. Finally, chores give parents the opportunity to express their appreciation for their children's help in situations that are real and tangible to the children. This forms the basis of self-confidence, and also ties the family together in a bond of mutual support and caring. The importance of parental expectations has been highlighted in a recent national survey of over 270,000 adolescents. Over three-fourths of the survey respondents cited appropriate, clearly stated expectations and standards for accomplishment as key to their success.

Development

Children begin with household chores as soon as they have the motor development to do so, usually by the age of three. In fact, children of this age often enjoy helping and imitating their parents in household cleaning duties and tasks. Early chores should involve the mutual cooperation of the parent and child. As the child matures in age and competence, you can reduce your direct involvement. In general, the progression of chores moves from simple to complex, and also from chores that focus on self-care to chores that help the family in general. For example:

Age	Chores
Pre-School (3-5 years)	Focus on immediate self-care and imitation: dress self, pick-up own toys, help clear table, "help"/imitate parents in other tasks
Early Elementary School (6-8 years)	Establish routines for self-care and expand into tasks for family welfare: clear and set table, empty garbage, put away clean clothes, pull weeds, feed pets
Late Elementary (9-11 years)	Increase self-management and skill level of chores: simple food preparation, wash car, sort laundry, simple yard work, exercise and groom pets
Secondary School (12-16 years)	Focus on skills for independent living and self or shared-group responsibility: cook meals, do laundry, perform repairs to house and car, heavy yard work

Establishing chores that are appropriate to your child's age and skill level is important. Start with relatively short and simple tasks, then move to tasks that offer mild challenge. First demonstrate the task: provide some pointers and, as the task is learned, offer more recognition and support than direction. Even if their work is barely adequate, they'll feel more motivation to improve the quality of their work the next time, if they feel proud of and appreciated for their effort.

What Can I Do as a Parent?

- Recognize that assigning chores is an essential task of parenting. In doing so, you help your child to learn that they can make an important and useful contribution to the care and support of the people they love.
- Acknowledge your children for their work. Give recognition for both their effort and for their actual contribution. Point out what has been improved by their effort, so that they can begin to develop their own self-appraisal skills.
- Begin by assigning only one or two chores. Choose chores that are relatively simple to do, and that may be of some interest to the child. Often, children show some interest in helping their parents do chores that are beyond their abilities. Even though it may take longer for you to do the task, try to find a way to include the child so that they may begin to develop a sense of contribution.
- Try to find a chore that can be done daily. This helps your child to establish a routine and it easier to remember than a chore that is done only on a weekly basis.
- Don't expect your children to remember to do chores without prompting. This will only lead to frustration for you, and discouragement for your children. Instead, consider ways to cue them about their chores. This might include notes or post-its left in common areas, or a regular check-in time each day. Some parents and children find it helpful to use a chore-chart, placed in a prominent area such as the refrigerator, bathroom mirror, or child's bedroom door. List each child's name, the chores to be completed and space for days of the week. Involve your child in evaluating and checking off the work that they have completed, so that they develop standards for performance as well as a sense of accomplishment.
- If your child wants variety, prepare a list with alternatives they can choose, or a jar from which they can draw a slip of paper with a chore listed.
- Once a chore is assigned, see that it is completed. If you let your children avoid it, the importance of the chore is diminished in their eyes and also your credibility with them is reduced. Take whatever time is needed to provide the supervision required to see them through the task. Their resistance will reduce over time when they see that you are firm in your expectations, and their skill will improve.
- In general, chores should be completed before play is allowed. If they complete their work before play, you will all feel more relaxed and positive. Some children prefer a break for play or snack before launching into chores or homework after school. If you agree to this, make explicit plans for when chores will begin.
- Assign chores so that both sons and daughters have equal opportunity to learn a wide array of skills. Both boys and girls need to be familiar with meal preparation, laundry, household repair, auto mechanics, cleaning and other "survival skills".

Should You Pay for Chores?

Should you pair chore completion with earning allowance or other rewards? This depends on your beliefs and values. Some parents believe that this pairing prepares children for responsible wage-earning as adults. Other parents think that chores are contributions to family maintenance, not a "job" for pay. Still other parents consider allowance as a means to teach their children money management, and want to keep this separate from chore completion. Any of these approaches can be successful, and there are good reasons to support them all.

Whichever of these ideas you believe in, it is important that you form them clearly in your own mind. Then, explain them clearly to your children in language that is appropriate to their age level. For example, a five year-old may be satisfied with the explanation, "Everybody has a job to help out the family. I appreciate it when you do yours." An older child can understand a more detailed explanation of how the chore fits into the overall family maintenance, or how their earning their allowance can give them the opportunity to decide how to budget their discretionary money.

If you *do* give allowance, pay, or other tangible rewards, they should always be combined with verbal recognition and specific, positive acknowledgment of what was accomplished. The relationship between the chore and payment should also be specified, and must be honored. If your child accomplishes the chore, the payment should be made, regardless of any other misbehavior that occurs. If the misbehavior is unrelated to the chore, then set a separate consequence for the misbehavior.

Summary

Chores offer an excellent opportunity to teach responsibility, import family values, and strengthen positive bonds with your child. With patience and support, you can foster competence, self-esteem, and a health mutual respect with your child.

Resources

Barnes, B. (1997). *Ready for Responsibility.* Zondervan Publishing. *In addition to basic ideas about chores, this book includes longer lists of specific shores that are appropriate for different age levels.*

Eyre, L. & Eyre, R. (1984). *Teaching Children Responsibility.* Simon & Schuster. *The Eyres offer many creative and down-to-earth ideas for teaching responsibility and also structures them into a twelve-month program that can be adjusted for age level.*

Rosemond, J. (1989). *John Rosemond's Six-Point Plan for Raising Healthy Children.* Andrews & McMeel. *An excellent and very readable guide for instilling responsibility and self-discipline in your children.*

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Online Advertising and Children

Guidelines for Advocates

by Victoria Stanhope
National Association of School Psychologists

Background

While cyberspace provides children with a powerful educational tool, it can also make them prey to advertisers eager for new consumers. Currently, more than a million children are online, with that number projected to reach fifteen million by the end of the century. With more schools gaining access to the Internet, teachers and school professionals should be aware that it is a highly unregulated medium that has commercial sites vying with educational sites to gain the attention of children.

Advertisers often ask children to give out personal information, including name, address, phone number, favorite product information and facts about family members before giving them access to online areas or in exchange for free merchandise. Often they have animated product "spokespersons" that send children e-mail to develop a specific brand loyalty at a very young age. Major companies that are involved in online advertising include Kelloggs, Frito-Lay, Disney, McDonalds and Warner Brothers. The under-18 market is highly lucrative with children spending an estimated $160 billion of their families' incomes on products.

Companies are hiring psychologists to find out the "hidden motivators" that draw children into cyberspace consumer-driven relationships with little parental oversight. Unlike television, which recognizes the special vulnerability of children to advertising and has certain safeguard measures, the information superhighway has no such safeguards. A survey of advertising by the Center for Media Education even found that some children's areas in the commercial online services contained unlabeled advertising.

Guidelines to Protect Children

In response to these deceitful practices, children's advocates are calling for guidelines for advertisers to ensure cyberspace is a safe and productive environment for children to learn. These are some of the ways you can help:

- Teach children that they should not give out any personal information in cyberspace, just as they should not talk to strangers in their neighborhood.
- Talk with parents and make them aware of the dangers of online advertising.
- Educate your local PTA, school board and other community groups about the issue.
- Make sure your school has policies that restrict the use of commercially-oriented areas.
- Complain to companies that use deceptive practices to target children online. Your voice is important.

Resource

The above Information comes from the Center for Media Education's Action for Children in Cyberspace Project. To learn more, order a copy of the report, "Web of Deception: Threats to Children from Online Marketing" from the Center for Media Education, 1511 K St. NW, Suite 518, Washington, DC 20005; (202) 628-2620; e-mail: *<cme@cme.org*, web site: *www.cme.org/cme>*

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Parenting
An Annotated Bibliography

Resources for Child Management

Bean, R. & Clemes, H. (1990).* How to Discipline Children Without Feeling Guilty. *Whole Child Series.

Originally written in 1978 and revised in 1990, *How to Discipline Children Without Feeling Guilty* is one book in a series of four. The series covers self-esteem, discipline and responsibility. The "Discipline" book consists of approximately 70 pages, with chapters being one to two pages in length, written in an easy-to-understand style. Topics are organized from general to specific. Beginning the book with a discussion of discipline, Bean gives parents permission to be authority figures. Chapter 8, entitled "Steps in Establishing Rules and Limits", is a brief yet excellent discussion on how parents can observe their child at home, analyze the behavioral concern and set up rules and consequences. Star charts are explained and the book concludes with a chart listing 30 chores and when children are developmentally ready to perform them. The book is a quick, common-sense reference tool that tries to help empower parents not only to discipline children but realistically develop appropriate understanding that discipline teaches responsibility.

Canter, Lee (1988).* Assertive Discipline for Parents: Revised Edition. *Harper Perennial.

This book is a practical guide for parents who want to effect positive behavioral changes with normal children who are typically difficult to manage or resistant to parental direction. It is not written for parents of children with severe emotional and/or behavioral disorders. Canter helps parents identify why children's misbehaviors or inappropriate behaviors continually recur, even after parents feel they have done everything possible. Canter presents a step-by-step guide to help parents learn "assertive discipline" techniques, with specific strategies and alternatives for individual behavioral problems. He includes a chapter of commonly asked questions from parents with answers that are consistent with assertive techniques. Helpful information regarding how home and school can work together to reduce school behavior problems unites parents and teachers in a tight team. The appendix contains discipline plan worksheets and a quick reference guide of typical behavior problems with positive and negative consequences. While this book is designed for parents who feel that their discipline techniques have not worked, it is a book that would be valuable to anyone who interacts regularly with children.

Dodson, Fitzhubh (1978).* How to Discipline with Love. *A Signet Book.

While readers might approach this nineteen-year-old book on parenting with skepticism, they could well be in for a surprise. Dr. Dodson's definition of discipline, which is presented early in the book, is straightforward: "discipline is teaching — that goes on all the time." He spends the rest of his book offering parents his insights on how to discipline effectively. The first half of the book offers an overview on how to implement twenty different discipline strategies, ranging from environmental control to family councils. For every strategy presented, a variety of real-life applications are provided. The second half of this parenting guide describes how to apply the twenty strategies across the various ages and stages of child development from infancy through late adolescence. The importance of matching discipline techniques with a child's developmental level is stressed. Guidelines on when it is appropriate to seek professional help are also provided. While he does not gloss over the challenges parents face, Dr. Dodson's upbeat tone and clear writing style make the book both enjoyable and informative to read. Despite its age, this book continues to be a reassuring, thoughtful and useful reference on discipline for today's parents.

Gordon, Thomas (1989).* Discipline That Works: Promoting Self Discipline in Children. *A Plume Book.

One of the pleasant surprises of this readable, parent-friendly 240-page book is how Gordon seems to anticipate the quick arguments some might have for his premise that excessive praising/rewarding — while a better alternative than any punishment — may not be nearly as fruitful as some would believe. By chapter three, the reader begins to recognize the everyday difficulties of trying to implement positive reinforcement with perfect consistency and regularity for one child, let alone for siblings or a classroom! Gordon's presentation of noncontrolling methods of changing children's behavior, models for the use of "I"-messages and conflict resolution, etc. could easily be implemented in nearly every home and classroom, and allow parents the luxury of being able to enjoy their children, as opposed to having to struggle with them. While generally readable, the book must be studied to be effective.

Kaye, K. (1984).* Family Rules: Raising Responsible Children. *Walker and Company.

Parents looking for a structured, concise and practical approach for dealing with their children's discipline problems will find reading Dr. Kenneth Kaye's book, *Family Rules: Raising Responsible Children,* extremely beneficial. The author, a child psychologist, stresses that families must have a system of clear and firm rules with consistent consequences applied when rules are broken to manage behavior effectively. Dr. Kaye's fundamental premise is that children need structure and consistency if they are to build the self-esteem and competence needed to make appropriate decisions in life. The first part of the book provides a well-articulated description of how to make rules that reflect important family values, choose appropriate consequences and how to escalate consequences when problem behaviors persist. The book is rich with helpful examples to illustrate key points as the principles are applied to all age ranges from preschoolers to adolescents. Also covered are techniques to analyze the causes of misbehavior and the importance of providing positive attention as a means to encourage appropriate behavior. Specific issues such as drug use, sex, step families and single parenthood are also discussed in detail. The length of the book should not deter parents from perusing it as it is quick reading, and parents need not read every chapter to understand the critical concepts.

Langston, Teresa A. (1994).* Parenting Without Pressure. *Navpress.

Ms. Langston has produced a highly readable, well organized book which provides an excellent resource for parents looking for help with discipline. Ms. Langston writes directly for parents and maintains that discipline should be used to teach children positive decision making, reduce family chaos and conflict, and increase the time needed to build positive parent-child relationships. The centerpiece of Ms. Langston's program is a family workbook constructed for each child which contains family rules, consequences, and expectations. Discipline revolves around the written contents of the workbook. Ms. Langston "walks" the reader through the construction and use of the workbook, which is meant to be a "living" document changing according to the needs of the family and the development of the child. Although adaptable to all age groups and a variety of discipline problems, the book is written with emphasis on discipline for oppositional adolescents. This emphasis is derived from the hard-won insights from personal experience that Ms. Langston uses to illustrate a concept or process. In addition, the author uses careful application of learning theory in the reinforcement and shaping of positive behaviors while extinguishing negative behaviors.

MacKenzie, R. (1993).* Setting Limits: How to Raise Responsible, Independent Children by Providing Reasonable Boundaries. *Prima.

Dr. MacKenzie has set out to help parents become aware of their style in shaping the behavior of their children and then offers ideas for more effective methods of dealing with non-compliance. Using enhanced communication and "time out", he advances his theory of less stressful ways of fulfilling consequences of child behavior. The book can be used as a guide for parent groups and some suggested questions for those groups are provided. The book can be used with preschoolers to teenagers. The author provides good support for parents seeking to establish boundaries without physical or overly restrictive method.

Martin, M. and Waltman-Greenwood, C. (Eds.) (1995). **Solve Your Child's School-Related Problems.** ***Harper Perennial.***

Drawing from materials provided by the National Association of School Psychologists, these editors have compiled an invaluable resource guide for parents seeking answers to questions about their children's school achievement and behavior. In addition to information about testing, special education and academic skills, chapters address anger control, conflict management, bullying, lying, motivation, homework and responsibility. Other chapters provide information about factors that can interfere with successful discipline and school performance — anxiety, assertiveness, depression, fears, self-esteem, retention and disabilities. Each chapter is brief, offers general information about the topic, suggestions for parents and resources for further reading. This book will be helpful to parents of children just entering school through those struggling with challenges of parenting teenagers.

Munger, Richard (1993). **Changing Children's Behavior Quickly.** ***Maison Books.***

This 208-page softcover book is written on an easy-reading level for parents of children two years of age and up and is designed to be comprehensible to all, including families who may be unable to benefit from traditional sources of help. The importance of setting clear behavioral limits in order to prevent the development of anxiety when limits are not given is emphasized. Techniques illustrated by charts which can be copied and "posted on the refrigerator" are given that "can be learned quickly, used immediately, and for most behavior problems give quick results". Cartoons are used to illustrate key points. Information is given on dealing with communication problems, hyperactivity, academic motivation, divorce, enuresis and healthy life styles, as well as separate chapters for parents and children on rule setting. Professionals working with parents will find the book a helpful supplement. It is recommended that parents investigate information about exceptional education with their local school districts rather than to rely solely on information given in the book.

Nelsen, Jane (1987). **Positive Discipline.** ***Ballantine Books. (New edition available, 1996)***

Jane Nelson's book is a well-written practical guide to child management targeted for both parents and teachers. The book describes a theory of behavior based on Adlerian psychology and prescribes a discipline approach engendered with kindness, respect, firmness and encouragement. Much of the book deals with the effective application of techniques and strategies used to deal with a wide array of misbehavior. Discipline is presented as an educational process that helps children achieve positive character traits and a healthy self-image. Readers confronted with the challenges of the role of a child "caregiver" will find this book a most valuable resource.

Weinhaus, E. & Friedman, K. (1991). **Stop Struggling With Your Child.** ***Harper Perennial.***

This book is full of basic parenting tips. It is easy to read and well organized with very simple solutions to some of the less severe challenges of child-rearing. The conclusion of each chapter summarizes the discussion in clear terms under a heading of "Points to Remember." The book is well written and filled with realistic parenting advice. However, many parents working to implement the solutions in this book may find that they need an additional support system, such as a school or agency-based support group, to help them implement the techniques presented.

Williamson, P. (1990). **Good Kids, Bad Behavior: Helping Children Learn Self-Discipline.** ***Fireside Paperbacks.***

Divided into three main parts — (1) Building a Positive Mental Attitude, (2) Back to the Basics, and (3) The Mechanics of Discipline — this book gives parents some behavioral plans to use in parenting. Strengths of the book include its readability, format and practicality. Especially good are the segments concerning positive reinforcement vs. bribery, the use of punishment and time-outs. The author states that positive reinforcement puts the responsibility for appropriate behavior on the child; bribery places the burden wrongly upon the parent, and that punishment used in conjunction with positive reinforcement can be an effective behavioral management tool. Time-outs are viewed as positive techniques as long as they aren't used as punishment. Parents are encouraged to read this book in an effort to gain insights into the behaviors of their children.

Windell, J. (1991).* Discipline: A Sourcebook of 50 Failsafe Techniques for Parents. *Collier Books. (Macmillan Publishing Co.)

The idea that parents need to draw on many discipline techniques from a bag of parenting tricks forms the basis of this book. Windell delivers what the book's title promises, from tips on how to define limits to the best way to give time-outs and ways to foster self esteem, to ideas on improving the parent-teen relationship. This parenting guide is directed toward ages preschool through the teenage years, with an eclectic theoretical orientation. Windell draws on what he calls the three basic approaches to parenting: the natural and logical consequences approach; the communication/ respond to the child's feelings approach; and the behavior modification approach. However, because Windell sees reliance on one approach as too limiting, variations on all three of these techniques are included along with many other practical ideas. The discipline techniques are divided into helpful categories, such as Techniques that Encourage Desired Behavior (give praise and attention) and Techniques that Correct Behavior (define limits, make a contract). Also useful are chapters on the Ten Worst Discipline Techniques (belittling, taking anger out on kids) and How to Get Kids to Do What You Want Them to Do (establish clear and consistent rules). A strong component of the book is the emphasis on ways to improve parent/child communication.

Windell, James (1994).* 8 Weeks to a Well-Behaved Child: A Failsafe Program for Toddler Through Teens. *Macmillan Publishing Co.

Windell's parent-training courses are presented in this award-winning 8 week step-by-step program. The actual 8 week "course" keys into the development of parent management skills and is soundly based on research and behavioral principles. Examples and discussions of discipline techniques, such as time-out, removal of privileges and "fair" and "unfair" punishment, are presented. Practical exercises of the specific techniques are employed per week. Although this is an easily readable book that is well formatted, a parent's endurance may wane without a supportive setting and professional feedback provided through actual in-person training sessions. Generally, this book is a good reference for specific behavior management techniques for parents.

Young Children

Dreikurs, Rudolph & Saltz, V. (1990).* Children the Challenge. *A Plume Book. (New Printing)

This book's cover indicates that it is a "classic work on improving parent-child relations — intelligent, humane, and eminently practical". Dreikurs' work is indeed a classic and has been the foundation for many other parent educators who have followed in the "democratic parenting" philosophy. In 39 concise chapters and with numerous examples, *Children* highlights key parenting principles, including encouragement, natural and logical consequences, mutual respect, avoiding power struggles and the importance of having fun together. Although the principles described apply to children of all ages, this book appears most helpful for parents of preschoolers and elementary-aged children. First published in 1964, Dreikurs' concepts remain sound; however, many of the examples may be dated. One of the most useful sections of this book is the chapter about children's mistaken goals — essentially why kids become discouraged and reasons why they then choose inappropriate behaviors. Another helpful chapter is Chapter 24, "Stay out of Fights," which describes why parents should avoid rescuing children when they are in conflict with siblings.

Schaefer, C. & DiGeronimo, T. (1991).* Teach Your Child to Behave: Disciplining With Love, From 2 to 8 years. *Penguin.

Teach Your Child to Behave: Disciplining with Love, from 2 to 8 years is an easy-to-read, informative book outlining positive parenting skills that will lead to effective discipline techniques through a three-step program. The first step examines the role of positive parent/child relationships and good communication skills in teaching the child to behave. Unconditional love, quality time, preventing problems and setting good examples are some of the issues explored during this first step. Steps two and three of the program teach specific strategies for setting and enforcing limits. Issues examined include the three characteristics of a well-set limit, the use of nonverbal cues, four methods of enforcement and five kinds of penalties. Further information is provided in looking at problem parenting styles and their remedies, specifying 30 common discipline problems and how to resolve them, and reviewing a helpful guideline of child development to determine if behaviors are willful disobedience or caused by the child's developmental stage. This book does a comprehensive and effective job in demonstrating the use of discipline methods to teach appropriate behaviors to children.

Wyckoff, J. & Unell, B. (1991).* Discipline Without Shouting or Spanking. *Meadowbrook Press. (Simon and Schuster).

This book is designed to be a convenient, reader-friendly reference for parents who encounter the misbehaviors of children between the ages of one to five years. The strategies and guidelines presented emphasize a brief, direct and immediate response to the most common problematic situations exhibited by preschoolers. Each chapter discusses a behavioral topic, offers advice to parents on how to prevent misbehavior from occurring and lists suggestions on how to solve problem situations. The addition of case histories illustrates the application of principles discussed throughout the chapters. The authors combine both a parental and professional viewpoint in their presentation of each topic. The information discussed is data based and endorses the theoretical orientation that supports the use of practical and natural solutions to resolve problem situations.

Wyckoff, J. & Unell, B. (1991).* How to Discipline Your 6-12 Year Old...Without Losing Your Mind. *Doubleday & Co.

This book is a direct and easy-to-read practical reference guide for parents in managing common behavior problems in six to twelve-year-old children. The authors have combined their professional and personal parental experiences, as well as those of other parents, to advocate a developmental perspective in understanding and approaching behaviors of the six to twelve-year-old child referred to as the "childolescent years". A chapter on developmental milestones for each age is provided as a guideline. The authors begin with a short chapter describing discipline as a teaching system for parents and include explanations of basic premises for disciplined parenting. The authors also include a discipline dictionary which defines terms used throughout the book (e.g., contract, negotiation). Remaining chapters consist of various sets of common behavioral problems with practical suggestions for prevention and problem-solving, tips on remedies and common pitfalls, and short case histories demonstrating the application of the authors' suggestions. The book appears to be a useful guide for successful disciplining of common behavior problems. The book's practical and easy-to-read format is appealing and would serve as a helpful reference for anyone dealing with children in this age group.

Teens

Bluestein, J. (1993).* Parents, Teens, and Boundaries: How to Draw the Line. *Health Communications.

Practical strategies for boundary setting for teenagers is the emphasis of this simply and clearly written paperback. Twenty relationship-building techniques are explored, teaching parents how to avoid conflict, resolve problems and establish the foundation for mutual love and respect between themselves and their teenagers. Each chapter contains a series of exercises that encourages the reader to reflect on the experiences that have contributed to their parenting practices and beliefs. The book makes the assumption that most of us have been conditioned *not* to set boundaries as a way to avoid the negative reactions of others. *Parents, Teens, and Boundaries* would make an excellent resource for teaching a parenting group due to its format which could generate a great deal of discussion.

Nelson, J. & Lott, L. (1994).* Positive Discipline for Teenagers: Resolving Conflict with Your Teenage Son or Daughter. *Prima.

This is a reference book to which parents will turn for direction on specific problems. Written with a conversational tone, it can help parents to educate, challenge and support children in an atmosphere of mutual respect, and to develop and use sound judgment without being judgmental. The authors emphasize firmness with dignity and respect with the goal of teaching young people self discipline, judgment, and responsibility. The authors' goal is to help parents seek understanding and help in building a satisfactory relationship with teenaged children, though many of the concepts are very applicable to younger children. Most helpful is to read the book prior to the teenage years and then review its principles as needed, since the concepts of mutual respect between child and parent need to be well established before the teen years. There is an extensive appendix, including study guides of self-help activities arranged to coordinate with each chapter and a bibliography for further reading for parents with a section on information for special problems; an appendix gives techniques for handling concerns following each chapter. Areas covered include: long term goals, values of mistakes, lifestyles, modeling, consequences and punishment, techniques for follow through, letting go and communication.

Dinkmeyer, D. & McKay, G. (1990).* Parenting Teenagers: Systematic Training for Effective Parenting (STEP), Revised Edition. *American Guidance Service.

This is a self-help book for parents of middle and high school students. It is designed to be used alone or as the text for parent training groups. In addition, parents are directed to existing local STEP groups as sources of assistance. The book is a 10-week self-study program with specific homework aids and a chart of chapter highlights. Cartoons illustrate main points. Highlighted boxes contain practical examples of techniques. All STEP programs identify four goals of misbehavior. This text introduces three additional teen goals: excitement, peer acceptance and superiority. Other concepts of the STEP program includes the use of encouragement, communication and family meetings. The use of reward and punishment to change teen behavior is discouraged. The use of logical consequences is recommended. The final chapter deals with special topics of family organization (divorce, single parents, step-parents and spousal disagreement) and a variety of teen behavior problems (lying, stealing, sexual activity, violence, alcohol and pregnancy). The text is very readable and well organized.

Weinhaus, E. & Friedman, K. (1988).* Stop Struggling With Your Teen. *Penguin.

This little book (64 pages) is a concise nugget of wisdom for parents. It covers defining who owns the problem — Kid Life Problems belong to kids — and yet asserts parental rights. It emphasizes is "I messages," though the authors don't call them such, and experiencing natural consequences.

Special Concerns

Eastman, M. & Rozen, S. (1994).* Taming the Dragon in Your Child: Solutions for Breaking the Cycle of Family Anger from Toddler to Teens. *John Wiley & Sons, Inc.

This book examines anger and how it is expressed, a problem often confronting parents. Its five parts investigate meeting the dragon, watching it change as the child ages, identifying old and new ways of dealing with it, parenting strategies and challenges with special populations. Buried in the middle of this book are excellent strategies for parents on changing patterns of behavior for themselves and their children. Good ideas are presented on talking with children of various ages. Many familiar phrases, such as "Grandma's rule" and "I messages" are incorporated in the strategies to open communication and establish a family discipline plan that is more proactive than reactive. The beginning of the book falls short in that it fails to separate definitively the emotional response of anger from the behavioral/action response. The book is most helpful to parents beginning near part III, where the book introduces realistic ideas on changing behavior patterns in times of conflict, plus strategies on opening communication and establishing discipline plans to teach decision-making skills.

Kurcinka, M. (1991).* Raising Your Spirited Child: A Guide for Parents Whose Child is More Intense, Sensitive, Perceptive, Persistent, Energetic. *Harper Perennial.

The word that distinguishes spirited children from other children is *more*. They are normal children who are *more* intense, persistent, sensitive, perceptive and uncomfortable with change than other children. It is important to note that the children discussed in Mary Kurcinka's book are not children who have Attention Deficit Hyperactive Disorder (ADHD). They are children with spirited behavior that falls within the broad range of normal developmental behaviors. This book deals with the 10-15% of children who are born with a super set of sensors, who never fall into a schedule, who experience every emotion and sensation deeply and powerfully, who hate surprises and who possess incredible energy. This book provides useful and practical tips for parents of spirited children. The book will help them understand their child's and their own temperamental traits. Strategies for handling a variety of situations are illustrated with both personal insight and authoritative advice. The positive approach taken is reassuring to parents as they attempt to understand the challenging child. Homey how-to's minimize the difficulties of the parent-child interaction. The book is an easy read with an interactive presentation.

Nelsen, J., Erwin, C., & Delzer, C. (1994).* Positive Discipline for Single Parents: A Practical Guide to Raising Children Who are Responsible, Respectful, and Resourceful. *Prima.

This book deals with the feelings and challenges specific to single parenting. Issues of guilt and anger, as well as the impact of parents' emotional feelings on their children, are discussed. Several common parental dilemmas related to single parenting or to specific feelings children experience growing up in a single family (i.e., feelings of loss) are detailed with helpful and appropriate parental responses offered. Tips for dealing with time management and delegating responsibilities are given. Many of the parenting principles presented in the book are rooted in solid parenting concepts irrespective of the parents' marital state. Specifically, many of the parenting suggestions described in the book are consistent with Don Dinkmeyer's principles outlined in *Systematic Training for Effective Parenting*: Reflective Listening Techniques, Four Goals of Misbehaviors, Natural and Logical Consequences, Family Meetings. This book also is realistic in describing the job, financial, parental and social pressures that can cause a single parent to feel overwhelmed. This book would likely be a helpful resource to single parents with school-age children, particularly children from kindergarten through eighth grade. The book is both realistic in identifying difficulties impinging on single parents and is also firmly grounded in proven and accepted parenting principles.

Rogers, Florence K. (1979).* Parenting the Difficult Child. *Chilton Book Co.

It is unusual to find a book on difficult children for parents that is both complete and readable. Rogers' personal experience and training include: parent of two "difficult" children, degree in psychology, extensive research background, free-lance writer. The book has abundant fodder for teachers, administrators, psychologists and physicians. In the late 1960's and 1970's, Rogers shaped a view of Attention Deficit Disorder drawing from authors who were just starting to attract attention, who are now titans in the field. This book is targeted for parents. It gives reliable how-to guidance and a sympathetic comfort that can only come from one who has "been there". In that sense, the book will never be dated. Since "Trying to help parents get rid of bad feelings — guilt, inadequacy, anger, frustration — is really the whole point of this book," Rogers can be forgiven for a fling with the then-promising Feingold diet. Divided into two sections, the first is concerned with hyperkinesis, now ADHD. Rogers gives a full accounting of the impact of ADHD on the child, family, school and various professions. The prevalence estimates she quotes are still accurate. Part two plumbs the problems confronting parents with compassion for child and parent, and with passion for the rights of both.

Teyber, Edward (1992).* Helping Children Cope with Divorce. *Lexington Books.

This book would be most valuable for parents to read before telling children of impending divorce. Guidelines are presented by topic. Expected reactions of children by age are clearly presented. Teyber's strongest point is the inclusion of sample scripts for parents to use when discussing divorce with their children. There is emphasis on the need for parental cooperation to assist the child's adjustment to divorce. The book is well written for a general audience and offers realistic suggestions.

Contributing Reviewers

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This bibliography was compiled by Gayle Macklem, NCSP, of the Massachusetts School Psychologists Association, and edited under the direction of Kathy Pluymert, NCSP, Chair of the NASP Children's Services Committee, and committee member Clare Marsh, NCSP. Contributing reviewers are all members of the Wisconsin School Psychologists Association. At the time of publication (June, 1997), all books listed were still in print or readily available at public libraries.

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Parents in Prison

A Handout For Parents

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Background

There are approximately 1.5 million children in the United States with a parent who is in prison. Children with parents in prison are five times more likely to become imprisoned themselves. Experts estimate that by the next decade, one half of all prisoners will be from a family which had a parent in prison. Being separated from a parent who is sentenced to prison can have devastating effects on a child. The child may experience guilt, anger, fear, and shame about his or her parent. These feelings, along with changes such as moving to a new house or apartment, going to a new school, having a new caretaker, giving up friends, and facing financial hardships also affect the child and family.

Child's Reaction to the Loss of a Parent Due to Incarceration

Children are upset by events related to the arrest and conviction of their parent. The following factors influence the child's reaction and adjustment:

Previous stressful events: Sexual, physical, and/or emotional abuse can cause the child to be more vulnerable to emotional difficulties.

The type of crime committed by the parent and the degree of involvement of the child: When the crime involves physical or sexual abuse of the child, mental health services should be sought immediately.

Age: Younger children are more likely to have difficulty understanding the arrest and imprisonment. They may not understand why the parent was involved in a crime or the extensive nature of time the parent will spend in prison.

Parent-child relationship before the arrest: Children will likely show stronger reactions to the loss of the primary caregiver, or the parent with whom they are closest. However, the loss of either parent can be a shock.

Presence of the child at the time of the arrest; peaceful or violent arrest: Children who witness a violent or aggressive arrest of their parent may be terrified and have nightmares or other symptoms of severe stress.

Child's knowledge and understanding of the crime or charges: Lying to children can create mistrust and can teach inappropriate behavior.

Publicity surrounding the crime or arrest: Cases which are well-known through the newspapers or television news can lead to shame and embarrassment for the child.

All of these factors may influence the child's reaction to the parent's arrest and imprisonment. Children may begin to show inappropriate ways of handling stress, such as fighting, poor concentration, immature behaviors, anxiety, depression, conflicts with other children, and poor schoolwork. Older children and adolescents may engage in delinquent behavior or substance abuse.

What Can A Parent Do?

- **Keep communication open and honest** about the absent parent. Children overhear adult discussion and may have questions. If not answered, these unanswered questions lead to anxiety. It is often a great relief for children to know where the parent is so that they can begin to explore their feelings and ask questions.
- **Prepare your child for each step of the incarceration process.** Explaining about the arrest, trial, prison, and parole helps the child understand what is happening and can help to minimize fear and anxiety.
- **Encourage visits to the parent in prison,** if possible. Children are exposed to views of prison life from television and newspapers which can increase their fears. Seeing the parent in prison can be an important and positive event for the child. Seeing the parent safe can reduce anxiety and provides important opportunities for the child and parent to feel loved and nurtured.
- **Encourage letter writing and other communication** between the parent and child. When visits are not possible, letters can reassure children that they are loved, remembered, and that their parent is safe. The parent in prison can describe a typical day, what s/he eats, what the prisoners do, etc. These things should be described in a positive, nonthreatening manner.
- **Seek support for yourself.** It is important that the remaining parent does not feel alone. Check with churches/synagogues and community agencies for support groups or counseling. Find ways to reduce your stress level such as exercise, proper diet, hobbies, community activities, etc.
- **Talk with your school psychologist, counselor, or social worker** about the situation so that your child can receive extra support. Some schools offer group or individual counseling. Let your child's teacher know that one parent is in prison so that s/he can be sensitive to the issues facing your child at school.
- **Send copies of school report cards, notes, and artwork** to the incarcerated parent so that s/he can feel that they are still part of the child's life.
- **Let children remain children.** Rely on other adults to help you deal with your feelings, stress level, loneliness, and fears, rather than relying on your children to take care of you.

Resources

Bloom, B. & Steinhart, D. (1983). *Why punish the children?* San Francisco: National Council on Crime and Delinquency.

Key, D. (1993). *SKIP: An elementary school-age program for children with parents in prison and children at risk.* PACT, Inc. 2901 W. 6th St, Suite D, Ft Worth TX 76107.

Key, D. & Eyres, G. (1987). *A child serving time on the outside.* Austin, TX: The Hogg Foundation for Mental Health.

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Running Away From Home

A Handout for Parents

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Background

Although modern society could be considered child-centered, children as a group and individually are not always happy with their life circumstances. In fact, some adolescents face such stressful problems in their immediate environments that they run away from home. Running away is defined in the literature as staying away from home at least overnight without the permission of a parent or legal guardian. Nationally, 1.3 million runaway and homeless youth live on the streets of America. One out of every seven children will run away sometime between the ages of 12 and 18 years. Most children who run away from home range in age from 10 to 18 years, with the peak age being 15 to 17 years. The most common destination is a relative's or friend's house. However, some children travel longer distances, especially those having transportation or money. Runaways typically return home within one day, although the average stay is three days. Most runaways who remain on the streets for more than three days must resort to prostitution, selling drugs, theft or panhandling to survive, and many use drugs to ease their emotional pain. Every year approximately 5,000 runaway and homeless children die from assault, illness and suicide.

Development

Current research does not establish a single reason for children running away. However, the most frequently cited cause is family problems. Adolescent runaways report poor relationships with their parents and cite communication problems as a major source of conflict in their homes. Many think that their parents simply do not listen to them. Conflict with parents over such things as defiance of authority, sexual activity, disapproved-of friends, poor academic performance, drug and alcohol use, and demands for material items also contributes to runaway behavior. Other causes cited by runaways include physical abuse, sexual abuse, incest, alcohol/drug abuse, pregnancy, legal difficulties and peer pressure. Although runaways come from all types of families, most are from single-parent homes and many are in foster placements or group homes. Limited communication with parents and guardians coupled with inadequate support from families, schools and churches can result in children believing that running away is the only solution. The majority of runaways are trying to escape problems they consider insurmountable. They are unable or unwilling to deal with their circumstances so they simply give up and run away. Research also suggests that runaway behavior may be associated with manic-depression. Depression is certainly an expected outcome of the difficulties runaways face, which may account for why some runaways attempt suicide.

Warning signs: Although the factors leading to runaway behavior are complex and varied, they are cumulative and there are warning signs that can be identified. Research indicates that the best predictor of running away is previous episodes of runaway behavior; that is, the child most likely to run away is one who has run away before. Other child behaviors and characteristics that may serve as early warning signs include expressions of anger and rejection toward parents, verbal threats of running away, drug and alcohol abuse, school failure, truancy, delinquency, marked changes in behavior or personality, poor peer relationships, low self-esteem and poor social skills. Additional factors include child abuse, parent-child conflict and communication problems, and constant battles with parents over independence. Certainly these warning signs are not unique to runaways; however, the presence of one or more of these signs increases the likelihood that a child will run away.

What Can I Do As A Parent?

Prevention is the best treatment for runaway behavior. Remember that children run away as a result of experiencing years of real or perceived problems they cannot or will not deal with. To prevent runaway behavior, parents must work to avoid those patterns of interaction that are associated with running away and must help their children develop healthy communication and coping skills.

- ***Make time to listen to your children.*** Many children who run away are looking for someone who has time to truly listen, especially someone who listens to their hopes and dreams. Listen not only to their words, but also to the feelings behind their words.
- ***Help children express feelings.*** Remember that children may lack the language and vocabulary to express their feelings verbally. Help them put their feelings into words. Talk about your own feelings, so they can learn from your example.
- ***Treat your children with respect.*** Avoid words and actions that embarrass, humiliate, and degrade them. In turn, you will earn their respect.
- ***Maintain open lines of communication with your children***. Children are most likely to communicate openly and positively with parents who do not preach, moralize, criticize, and blame. By avoiding such behaviors parents are likely to foster the kind of give-and-take communication that is so crucial to healthy relationships.
- ***Maintain constructive communication with school personnel.*** Ask them what you can do at home to help your children progress. Show your interest and concern by being involved in school activities and functions and by keeping informed about how your children are doing in school.
- ***Get to know your children's friends*** and their parents and monitor where your children are at all times. Being a parent means accepting responsibility for your children's behavior even when they are not with you.
- ***Establish some basic rules at home.*** Contrary to popular belief, most children want and need limits set on their behavior. Limit the rules to a few, develop them together, and then enforce them consistently and fairly. When rules are broken, impose consequences that are reasonable, respectful, and related to the infraction whenever possible.
- ***Help your children learn to solve problems on their own.*** When they encounter difficulties avoid giving them solutions; rather, guide them in finding their own solutions. The problem-solving skills they learn will help them make good decisions when they are away from you.
- ***Seek professional help*** when problems between you and your children persist. There are many professionals in every community — school psychologists, counselors, and social workers, as well as other community mental health professionals — who are able to help with such problems.

Resources

National Runaway Switchboard. Toll free 1-800-621-4000 (TDD for the hearing impaired 1-800-621-0394); 3080 N. Lincoln Avenue, Chicago, IL, 60657. Provides the following services:

- Establishes trust and rapport with callers.
- Helps the caller identify problems and focus on key issues.
- Helps the caller explore the facts and their feelings associated with the problems.
- Assists the caller in exploring available options.
- Arranges conference calls to parents.
- Provides message delivery from runaways to their parents or guardians.
- Arranges conference calls to shelters or other agencies to confirm available and appropriate services.
- Provides posters and brochures free of charge.

Runaway Hotline. Toll free 1-800-231-6946 (in Texas 1-800-392-3352). Provides confidential relay messages from youths to parents without revealing locations.

National Network of Runaway and Youth Services. (202) 783-7949; 1319 F Street NW, Suite 401, Washington, DC, 20004. Promotes development of responsive local services for youth and families.

Children of the Night. Toll free 1-800-551-1300 (or 1-818-908-4474); 14530 Sylvan Street, Van Nuys, CA, 91411. Provides runaway shelter for ages 11-17 and 24-hour hotline.

Youth Crisis Hotline (Runaways). Toll free 1-800-HIT-HOME. 24-hour hotline, with newsletter available. Provides referrals as well as some counseling regarding runaways, child abuse, eating disorders, gangs, molestation, pregnancy and suicide.

Hotline Resource

Directory of National Helplines: A Guide to Toll-Free Public Service Numbers. The Pierian Press, 1995.

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Self-care: Children Home Alone

Information for Parents

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Background

Self-care is the child care arrangement in which children under 14 years of age take care of themselves, and perhaps siblings or other children, without direct adult supervision. It occurs both before and after school hours, during vacations, and may include periods when the caregiver is sleeping after working a night shift. The term *latchkey children* describes children who enter an empty house using their own keys.

Self-care is a common, apparently growing child care arrangement for millions of school-aged children in the United States. The numbers of children cared for in this child care arrangement are difficult to determine because of factors such as multiple definitions of self-care, routine versus sporadic time spent in self-care, variations in number of hours spent daily and/or weekly, and the invisibility of children home alone. However, this form of child care is increasingly adopted as children grow older; by 12 years, about one-third of school-aged children take care of themselves for some portion of each day.

Children are engaged in self-care for a variety of reasons, including limited availability of child care, its high cost, lack of options because parents work part-time or irregular hours, and children's unwillingness to participate in what they perceive as "babyish" child care arrangements (such as "babysitters"). While most spend time alone in the family home, other children are found in, and may even prefer, public places where there are activities and limited supervision. For example, some children are found at libraries for extended periods several times a week because their parents appreciate the supervision, safety and educational value of the library. Conversely, library staff are faced with issues of space and management. Generally, then, children are engaged in self-care because there are few acceptable alternatives and they appear to be sufficiently mature to care for themselves.

Initially, parents experiment with leaving their children unsupervised for increasing periods. After both parents and children are satisfied that the children cope with staying home alone, and nothing bad happens in parents' absence, self-care is adopted as a form of child care. In a few cases, parents opt for self-care in response to an immediate family crisis and continue it after the crisis has resolved.

The Impact of Self-Care

Relatively little is known about the impact of self-care, including special risk factors, when compared to other forms of child care. Parents frequently report that self-care provides benefits to their children, including development of personal responsibility and independence and the opportunity to learn basic survival skills such as food preparation, responding emergencies and distinguishing unfamiliar situations from dangerous ones. Nevertheless, they still experience uneasiness when leaving their children unsupervised and often express concern about too much television viewing, academic problems and victimization by individuals who take advantage of unsupervised children. Parents are concerned that the home might become a gathering place for their children's friends and/or the site of sexual experimentation and drug and alcohol use. Finally, self-care is apparently associated with problems in the work place for many parents, including reduced productivity, stress, absence from work and arriving late or leaving early.

Characteristics of Successful Self-care

Successful, safe self-care is associated with a variety of factors:

- ***Child's age:*** Between 10 and 12 years, many children demonstrate sufficient maturity in behavior and judgment to spend some time without direct adult supervision. However, children younger than the fourth grade usually lack the maturity and skills to care for themselves without adult supervision and are more likely to experience negative consequences of this child care arrangement.
- ***Safety*** at home and in the neighborhoods is a major priority and factor in the success of self-care, even when fears about safety are not justified. Indeed, security considerations apply at all times, including periods when children are supervised or are not facing an emergency.
- ***Time in self-care:*** The amount of time spent unsupervised is related to the success of child care. More frequent behavior problems, such as experimenting with drugs, alcohol and sexual activity, and heightened risk of abuse, are associated with extended amount of time spent in self-care. Successful self-care is more likely when children are provided with indirect supervision by establishing privileges, restrictions and safety procedures, scheduling daily phone contacts with parents to check in and share the day's events, and identifying a trusted adult whom the children can contact in case of need.
- ***The quality of the relationship between parents and their children*** contributes to the success of self-care. When there are frequent conflicts between parents and children, self-care is often unsuccessful.
- ***Countering negative feelings:*** Boredom, loneliness, fear and resentment are often experienced by children in self-care. Boredom and loneliness may be related to a limited array of activities or opportunities that allow exploration of personal interests and development of skills. Fear may be precipitated by children's concerns about the safety of self-care and/or limited knowledge or resources for solving potential problems. In some cases, parental fears are communicated to the children to the detriment of self-care. Resentment is often fostered by parents' attempts to account for their children's time by requiring more chores or school-related activities than is expected of other children of the same age. Therefore, while they are common among latchkey children, these feelings demand joint consideration and resolution by parents and children.

Tips for Parents and Children

Federal and state governments and multiple agencies have provided pamphlets and brochures with general information about self-care and tips for parents and children. Guidelines from publication to publication are quite consistent. Their suggestions are organized here in three categories: (1) preliminary advice for parents and children, (2) safety considerations and (3) tips for children in self-care.

Before self-care begins, parents and children should:

- Consider the appropriateness of self-care in light of children's age and maturity, interests and abilities, safety of home and neighborhood, family circumstances and relationships, and alternative child care arrangements. If there is any question about children's maturity or comfort with self-care, it should be postponed.
- Decide what types of fun and interesting activities children may engage in without adult supervision. Refrain from filling hours with chores and academic activities.
- Design and write out a self-care plan that includes the kinds of decisions children are permitted to make as well as any prerogatives and restrictions. Children should know the limits of their authority; parents should not change or inconsistently apply rules before talking to their children. As self-care proceeds, parents and children reevaluate what works and does not work.

- Role play common, frightening, and emergency situations, such as answering the phone or door, making snacks, calling the fire or police departments, or evacuating the house because of an emergency. Fire drills are an important role play.
- Teach children safety procedures and how to make good decisions in emergency or dangerous situations. Discuss and problem solve children's fears for their safety and their concern about handling a variety of new situations.
- Rehearse how to place a call on rotary and push button telephones and what to say in an emergency call, including providing the home address and directions to the house.
- Teach basic first aid and location of a stocked first aid kit.
- Work out a plan for phone calls to parents, especially when and how parents want to be contacted.
- Establish ground rules for what activities are permitted during self-care such as limits on television viewing and phone calls, which appliances may be used, whether friends can visit, if children can go outside or somewhere other than home, etc.
- Review safety rules about matches, knives, and stoves.

To provide for the safety of their children in self-care, parents and children should:

- Tour the neighborhood to identify safe and dangerous circumstances or places.
- Modify unsafe situations by prohibiting children from going to particular places, providing first aid kits and smoke alarms with new batteries, removing fire hazards, reinforcing windows and doors and installing strong locks to keep the house safe from intrusion while permitting easy exit during an emergency, and establishing deterrents to home entry such as large and/or yappy dogs, fences and other barriers.
- Arrange for immediate access to neighbors and other trusted adults who can answer questions or be contacted in an emergency.
- Provide an accessible list of emergency phone numbers for fire and police departments, ambulance service, the poison control center, family doctor, parent(s), and other adults or friends. Include directions for when and how to use these numbers.
- Identify a safe, accessible hiding place for use in case of a home invasion.
- Hide an emergency kit containing an extra house key, money, phone numbers and other essentials in a safe, accessible place.
- Provide a written list of safety procedures.

Children should follow these basic rules of self-care:

- Beware of broken windows, open doors and other signs that your house may not be safe. Don't enter it unless you are sure it is safe, and then lock the door behind you.
- Never tell people at the door or phone callers that you are home alone. Say your parents are busy and offer to take a message.
- Keep your house key hidden. Don't give it to anyone and don't keep it in a visible place which would tell people you are going home to an empty house.
- Know how to quickly reach your parents, one or more trusted adults and emergency personnel such as doctors, police and the fire department.
- Never talk to strangers or accept rides from them.

- Never pet or chase unfamiliar animals.
- Never use stoves, sharp knives or other dangerous tools when alone.
- Identify scary or dangerous situations. Decide and then practice how to handle them.
- Know the rules about what you can and can't do when alone. If you are unsure, ask.
- Never break rules, even when encouraged by a friend. Your personal safety and your parents' trust would be risked.
- Think about self-care, including what does or doesn't work, what you like and dislike, and what makes you angry or scared. Work with your parents to choose strategies that makes self-care work for you.
- Don't panic. If you are afraid or have a problem, call a parent or a trusted adult.

Resources

Dowd, F. S. (1991). *Latchkey children in the library and community: Issues, strategies, and programs.* Phoenix: Oryx Press.

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Hayes, C. D., Palmer, J. L., & Larner, M. (1990). *Who cares for America's children: Child care policy in the 1990s.* Washington, DC: National Academy Press.

Vandell, D. L., Pierce, K., & Stright, A. (1997). Child care. In G. Bear, K. Minke and A. Thomas (Eds.), *Children's needs II: Development, problems and alternatives* (pp. 575-584). Bethesda, MD: National Association of School Psychologists.

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Psychologists

Siblings of the Handicapped and Chronically Ill

A Handout for Parents

by Sally Linton Burton, University of Idaho
Revised by Judy Bomze, Abington Schools (PA)

Background

The diagnosis of a handicapping condition or a chronic illness has a profound effect on a family. Siblings suddenly must adjust to severe changes in family's lifestyle and daily routine because increased time, attention, money and psychological support is directed at the disabled or ill sibling. However, it is imperative that siblings of the handicapped child adjust to the new situation because their reactions to the sibling with a disability can affect the adjustment and development of self-esteem in each child.

Siblings play important roles in each other's lives. Brothers and sisters take on many roles with each other: teacher, friend, companion, follower, protector, enemy, competitor, confidante, role model. When one of the siblings is disabled or chronically ill, these roles can be altered. Each child will respond differently toward the disabled or ill sibling. Children with poor coping skills will be more easily overwhelmed by stressful experiences. Children with poor parent-child relationships and unmet nurture needs will not tolerate well situations that may increase demands on them. Children who are in the midst of a developmental transition (e.g., starting school or puberty) also have decreased ability to tolerate other stresses and frustrations.

The responses and feelings of the nondisabled siblings tend to change over time as the sibling adapts to the disabled or ill sibling and as they get older. For example, preschool-aged children may feel confused, afraid, anxious and angry. The younger the child, the more difficult it may be for him or her to understand the situation. Elementary school-aged children may feel embarrassed or ashamed as they recognize differences between their sibling and someone else's brother or sister. Young adults may have future-oriented concerns. They may wonder what will become of their brother or sister and they may be concerned about how the people they socialize with will accept the sibling with a disability. They also may have concerns about planning their own families and their future responsibilities for the sibling with a disability.

Issues and Concerns

Parents and professionals are often unaware of the special needs and unique concerns of these nonhandicapped siblings. Typical problems confronting siblings of the handicapped include:

Embarrassment: Children with handicaps may embarrass their siblings by having seizures or calling attention to themselves through some unusual behavior which may cause peers, neighbors or strangers to stare. In the same way that parents feel that their children's behavior is a reflection of them, siblings identify with their ill or handicapped brother or sister. They may feel personally assaulted by stares and teasing, and read criticism into curious looks.

Guilt: Siblings occasionally may get angry at their brother or sister with a handicap or illness and may suffer feelings of guilt because they realize their anger has been directed towards behavior that their sibling cannot control. Consequently, they will have to learn how to deal with excess guilt. Healthy siblings may worry about "catching" or developing the problem, and they may feel guilty because they themselves do not have a disability. This may result in underachievement. A child may not want to do well because he or she feels undeserving of success.

Isolation: Siblings may feel a sense of isolation about sharing news about their brother or sister with their friends because of the negative reaction they might get. It may be difficult or embarrassing to explain to their friends why their brother or sister is in special education classes and needs special attention. Siblings also may have to restrain their enthusiasm about an accomplishment of their sibling with a handicap because their friends may consider this a trivial achievement and laugh at their brother or sister. Siblings may feel so stigmatized that they question their own normality. They may not realize that there are other children in similar situations. They may have no one to talk to about their situation, no one with whom to share negative feelings. They may not talk to their parents because they do not want to upset them or perhaps they feel that they will not be understood.

Resentment: Siblings sometimes feel conflict between their needs and those of their handicapped or ill brother or sister. They may resent the amount of time and energy their parents give to the child with the special needs. They may also misinterpret their parents' priorities, and engage in inappropriate behavior in an attempt to get their fair share of their parents' attention. Inappropriate behaviors may include imitating their sibling's disability or infantile behaviors such as thumb-sucking or tantrums.

While healthy siblings are normally the best equipped and most convenient baby-sitters for their handicapped or ill brother or sister, such responsibilities may directly conflict with the sibling's own needs. If excessive child care responsibilities deprive siblings of the opportunity to have time to themselves or pursue their own interests, then they may resent both their parents and their brother or sister with a handicap or illness.

Ambivalence: Siblings often feel angry at themselves, their friends and their sibling with special needs. They struggle with the pain of feeling ashamed and embarrassed, jealous and resentful, even though they also may love their brother or sister. Children also sense pain in their parents and avoid asking questions because they fear hurting their parents.

Emotional and Financial Consequences: There are tremendous emotional and financial strains in a family with a disabled or chronically ill child. Parents may be attempting to present a calm, relaxed, and confident exterior while inside they are in perpetual turmoil. Families may need to seek professional help to assist in communication, emotional stress, and perhaps to assist them in acquiring resources. As children get older, the financial problems will become more apparent (e.g., when specific clothing may be requested or outings with friends become frequent). Honest communication with children who are capable of understanding is important. Priorities must be set and some needs deferred. Vacation plans or leisure activities may be affected in order to accommodate special needs.

Future Concerns: Siblings are very concerned about the future of their handicapped brother or sister. They want to know about living and financial arrangements for the handicapped individual and their own chances of having a handicapped child. They also may be anxious about their future responsibilities for the sibling with a disability.

Pressure to Achieve: Often parents transfer unrealized expectations for the handicapped child to the other children. These expectations can create stress if they are unrealistic. Some children may shoulder the burdens of child care, housework, or may make major efforts to perform well in school, believing that in some way they must make up for the pain and sorrow of having a disabled or ill sibling.

What Can I Do As A Parent?

Conflicts arise when parents have a double standard for disabled and nondisabled children. Even though the child with the disability may need and receive more parental attention, the amount given may be perceived as unfair by nondisabled siblings. Some parents, on the other hand, may tend to overindulge the normal sibling in an effort to compensate for a brother or sister with a disability.

- ***Household chores*** should be evenly distributed among all family members and not become the sole responsibility of nonhandicapped siblings. Nonhandicapped children may become resentful if siblings with handicaps do not have to participate in family or household chores. Children with handicaps may team up with another family member to take some minimal part in household chores.

- ***Open communication*** is essential in a family with a handicapped child. The full impact of the handicap or illness should be talked about honestly with all family members, including the nonhandicapped siblings. Your nonhandicapped child has a right to factual and age-appropriate information regarding the handicap or illness. If this information is withheld, then they may invent answers to their questions, such as what caused the handicap or illness, and they may even blame themselves for the condition. Nondisabled siblings may require information that is developmentally appropriate throughout their lives. Read books with your nondisabled child, books that have been specifically prepared for the siblings of handicapped children (see resources below). Take the nondisabled sibling to visit the disabled child's school.
- ***Meet with your nonhandicapped sibling's teachers.*** It is important for the teacher to understand what your child is going through. Additionally, school may be the only place where your child feels relaxed and normal. The teacher may be able to serve as a confidant or provide moral support. Explain your child's behavior and reactions in light of being a sibling in a family with a child with a chronic illness or disability. Give the teacher a copy of this handout. If your child agrees, ask the teacher if you and/or your child could speak to their class about the disability or illness. Perhaps read a book to the class. Tell the teacher if the handicapped or ill child will be undergoing surgery or admitted to a hospital. Designate a friend or family member to communicate with the school if there is an unforeseen emergency. Finally, request frequent contact with the teacher in order to reduce the negative effects of family stressors on your child's education.
- ***Request that your child visit with the counselor or school psychologist.*** Ask if there is a support group for siblings of the handicapped or if there is any way to connect with a family in similar circumstances. If there is a sibling support group in your area, then check it out for yourself. If it meets your approval, then encourage your child to participate in the group. Your willingness to acknowledge sibling concerns will foster an atmosphere of cooperation between you and your child.
- ***Future concerns of the handicapped individual should be dealt with as a family.*** Siblings may want to know if they will have children with disabilities, and who will take care of and become responsible for the handicapped child when the parents become unable to do so. A visit with one of your local advocacy groups, such as The Association for Retarded Citizens, or a discussion with the family lawyer can help the family and the nonhandicapped siblings prepare for the future.
- ***Encourage and support your children's expression of their true emotions about their handicapped sibling with you.*** For many children, feelings often are not expressed in day-to-day family interactions and discussions, and are shared even less in school. Children need to express their emotions. If the child is mad at their handicapped sibling for embarrassing them at school, then share with them how you would feel if it were you who was embarrassed. Acknowledge their feelings, and allow them the right to be angry. Nothing diffuses the anger of a child more than parental respect of their feelings. Share with them stories of your own childhood and how you felt when your brothers or sisters made you angry.
- ***Spend time alone with your nonhandicapped children.*** Make plans to spend time alone with them and talk just about their activities, dreams and accomplishments.
- ***Provide as many opportunities for a normal family life as possible.*** This means inviting friends to visit, participating in sports activities and taking family vacations, even if that sometimes requires leaving the disabled child at home at home with a caretaker.
- ***Avoid seeing the sibling with the disability as the dependent.*** They should be trained early on to be as independent as possible and to make their own choices. It is equally important to avoid making the sibling without the disability adopt a parental attitude of responsibility toward the handicapped sibling. Furthermore, the best way to foster a positive relationship and a strong commitment among family members, is to allow them to choose the levels and intensity of the involvement with each other and to allow them to settle their differences by themselves.

- ***Remember the positives!*** Being a sibling of an individual with a disability offers several benefits. Some of these benefits include the ability to develop a sense of humor about dealing with awkward or unusual situations, tolerance and patience of others with lesser advantages and/or abilities, and flexibility. Other positive aspects include higher levels of empathy and altruism, increased sense of maturity and responsibility, and pride in the sibling's accomplishments. When you see these qualities in your nonhandicapped child, take the time to praise him/her.

Resources

Lobato, Debra. (1990). *Brothers, sisters, and special needs.* Baltimore, MD: Paul H. Brookes. *This text is worded in a clear format to inform parents and professionals of the needs of the children who have siblings with disabilities.*

Powell, T.H. & Gallagher, P.A. (1993). *Brothers and sisters: A special part of exceptional families* (2nd ed.). Baltimore, MD: Paul H. Brookes. *The authors are special educators who have combined a review of research on siblings of children with handicaps together with their own experiences and recommendations to produce a book which will be of considerable value to parents. The chapters include discussions about the unique needs of siblings with specific strategies to help them maximize their psychological and emotional growth.*

Seliman, N. (Ed.) (1983). *The family with a handicapped child.* New York: Grune and Stratton, Inc. *This volume focuses on a range of topics including legal issues, community service providers, working with families, counseling, and therapeutic interventions. Most importantly, there is a chapter entitled "Siblings of Handicapped Persons" by the author which includes an overview of research findings and discusses psychological prospects for siblings.*

Newsletters:

NASP Newsletter. A newsletter published for service providers. Available from: National Association of Sibling Programs, Sibling Support Project, Children's Hospital and Medical Center, P.O. Box 5371, CL-09, Seattle, WA 98'05-0371. Telephone: (206) 368-4911.

Special Parent/Special Child. Practical pointers for parenting handicapped children. This is a bimonthly newsletter designed to promote effective family functioning between parents and special children. Lindell Press, Inc., P.O. Box 462, South Salem, New York 10590.

Written Material for Siblings:

Bach, Alice (1980). *Waiting for Johnny Miracle.* Harper Row. About a high school girl with cancer.

Meyer D.J., Vadasy, P. F., & Fewell, R. R. (1985). *Living With A Brother or Sister with Special Needs.* Seattle, WA: University of Washington Press. *This book is written for young readers. The book offers factual information and emotional support to brothers and sisters with handicaps. This book provides useful and clear explanations about specific handicapping conditions. The book constitutes an excellent resource book for parents and siblings.*

Morgan, Fay. *The Pittsburgh Sibling Handbook.* Available for $3.50 from the Sibling Support Project, Easter Seal Society of Allegheny County, 632 Fort Duquesne Boulevard, Pittsburgh, PA 15222. *This 20- page handbook provides helpful information for children ages 8-13 who have a brother or sister with a disability. The booklet includes photos and quotes from children in the Pittsburgh area.*

Myers, Robert. *Like Normal People.* New Jersey: New American Library. *About a mentally retarded man who marries and lives independently. The story is written by the man's brother and is also about his life as the brother. A good book - interesting to read and a positive look toward future responsibilities.*

Shyer, Marlene (1978). *Welcome home, Jellybean.* Scribner. *A 12-year-old boy narrates the story of his sister's return home from an institution for the retarded.*

Sleptan, Jan. (1980). *The Alfred Summer.* New York: Macmillan Publishing Co. *About a 14 year-old boy, Lester, who has cerebral palsy and his mentally retarded friend, Robert. This book takes a good look at what it might feel like to have cerebral palsy. It also examines the feelings and viewpoint of Lester's parents and Robert's brother.*

For Sibs Only. Family Resource Associates, 35 Haddon Avenue, Shrewsbury, NJ 07702. Telephone (908)747-5310. *A newsletter published 4 times a year for siblings, aged 10 through teens, of individuals who have disabilities. Family subscription available for a fee.*

This revision/update was developed by Judy Bomze, school psychologist in the Abington (PA) School District and the parent of a child who is handicapped and his nonhandicapped brother. Thanks to Pam Beeman, school psychologist in Chico, CA, for her review and suggestions.

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Academic Motivation

A Handout for Parents

by Michael B. Brown, Ph.D., East Carolina University (NC)
and Patricia B. Keith, Ph.D., Alfred University (NY)

Home-School Connections

What is Academic Motivation?

A child who is academically motivated wants to learn, likes learning-related activities, and believes school is important. We want to help children develop a desire to do well in school because the children believe that learning is important and rewarding in their lives.

Development of Academic Motivation

Children are naturally motivated to learn when they are infants. A baby's struggle to reach a toy, learn to walk, or eat without help are examples of motivation to learn. This early motivation to learn is later applied to school-related activities such as reading and writing. When children are not motivated to learn, it is because something has gotten in the way of their natural motivation. They believe that they cannot do well in school-related tasks, and they stop trying or do not try hard enough because they don't think that it will make a difference. They become easily frustrated and give up when learning is difficult. Since they stop trying, they do not learn successfully. They do not get to experience the thrill of learning something new. They believe that any success they have is due to luck or circumstance.

Why do children develop these negative beliefs? Sometimes it is because of things that affect their *ability* to learn. Learning disabilities, difficult temperament, developmental delay, depression, or chronic life stress may make it harder for a child to learn in school. Children who have failed in school before are also very likely to stop trying to learn because they develop the belief that they cannot do so. The *attitudes* of adults can also influence children's beliefs about their academic success. Parents who have standards that are unrealistic can discourage their children's efforts. Competition in school (where someone always wins and someone always loses) can be very discouraging to children, especially those who may never be "the best" at school, even though they can learn a lot. Children who don't experience success or whose successes are not recognized may develop poor academic motivation. Children whose parents or peers do not think school is important or do not place importance on doing their best in school also can develop poor academic motivation.

Increasing Motivation to Learn

There are many things that parents can do to increase their child's academic motivation. Keeping good parent-child relationships and letting your child know that you think school is important can enhance academic effort. You can also help by teaching your child good study habits and providing recognition for his or her successes. Working as a partner with your child's teacher is also important. Here are some ideas to help you increase your child's motivation to learn:

- Be firm and fair when you discipline your child. Children need reasonable discipline to be independent and responsible.
- Teach your child to be responsible at home. Chores and expectations for proper behavior are ways of developing self-discipline that can transfer to school-related learning.
- Work hard to have a good parent-child relationship. Take time to do fun things with your child. Listen when your child talks to you, especially about school.

- Do family activities that encourage learning, such as visits to the library, museums or parks.
- Let your children know that you think learning is important and is the central purpose of school.
- Provide opportunities for successes. Children who feel successful are more likely to try new things.
- Talk with your children about your interests and likes.
- Help your children identify things that they enjoy and what they do well. Capitalize on their interests to build learning experiences. For instance, if your child likes baseball, you can encourage your child to read and write about baseball players or the history of baseball.
- Talk with your children about school and show an interest in their school activities.
- Talk with your children about their career interests and how school is related to a career.
- Be sure to praise your children for trying hard and for being successful. All children need to know when they are doing well.
- Balance praise and punishment when you are helping your child. Too much punishment can be discouraging. Make sure your child knows what is expected and gets some kind of recognition. Remember, rewards don't always mean getting money or privileges. Just telling your children that you are proud of them or you notice the effort they put into their work will make a big difference.

Teach Habits that Encourage Learning

- Have a set routine for school work. Your child should know when he or she is expected to work on their school work each day.
- Set up a place to study where your children have the needed supplies and as much quiet as necessary.
- Make sure your children finish school work at home before doing things that could distract them from doing their school work.

Work with Your Child's Teacher

- Show your child that you respect his or her teacher. Don't handle disagreement with the teacher in front of your child.
- Talk regularly with the teacher so that each of you know what is going on in school and at home. Waiting until report cards come out is often too late to make changes.
- Work with your child's teacher to make sure your child learns good study skills.
- Develop a system to give reinforcements at home for working hard in school.

If Your Child is Already Having Problems with Academic Motivation

- Talk with your child about the problem. Is he or she feeling confused or frustrated by the work? Does your child feel that he or she is trying hard to do well?
- Talk with your child's teacher to identify areas in need of improvement.
- Let your child know that you are willing to help them do better.
- Help your child identify things he or she does well so that the focus is only on areas of difficulty.
- Help your child identify things that he or she likes that could be used to help with school work (for example, if a child is interested in animals, have him or her read books about animals, make up stories about animals, etc.).
- Reward effort and productivity.
- Provide increased rewards for improvement.
- Limit things that interfere with learning, such as excessive TV, video games, computer time, etc.
- Increase the amount of time your child studies each day by a small amount — 5-10 minutes until you reach a reasonable goal (such as an additional thirty minutes per day).

Get More Help if Necessary

- Talk with your child's teacher, school counselor or school psychologist for help and advice. If there is reason to suspect an educational disability, request a comprehensive assessment from your school's special education team.
- Often, there are parents groups or PTA groups that can help you or provide support.
- Find out if instruction in study skills is available at your child's school.
- Don't be afraid to seek counseling or other help outside of school if necessary.

Resources for Parents

Brown-Miller, A. (1994). *Learning to learn: Ways to nurture your child's intelligence.* New York: Plenum Press.

Clark, L. (1996). *SOS: Help for parents (2nd Edition).* Bowling Green, KY: Parent's Press.

Levine, M. E. (1994). *Educational care.* Cambridge, MA: Educators Publishing Service.

Martin, M. , & Waltman-Greenwood, C. (Eds.) (1995). *Solving your child's school-related problems.* New York: HarperPerenniel.

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Charter Schools

A Handout for Parents

by Nicola Jordan, Ed.D., NCSP
Hilton Head, SC

Background

"School choice" has become an increasingly popular topic of debate in recent years, not just among educators and "school reformers," but also in political circles. Vouchers (also called "opportunity scholarships for children" by politicians) are annual stipends paid with public funds to parents who want to enroll their children in private or religious schools. Currently vouchers are available in only a few pilot programs and have been emphatically opposed in several states by voters who question the use of public funds for private schools. In response, some educators and politicians are embracing the new charter school movement, which is seen as a "school reform" compromise between providing additional money to the current system and infusing the private sector (including religious schools) with public dollars. The purpose of this handout is to address some of the charter school issues and to look at how early charters are working.

What is a Charter School?

A charter school operates under a contract negotiated between its organizers and a sponsoring body. The idea is that by lifting some of the restraints affecting the public schools, the charter school staff will be free to pursue innovative teaching methods that will improve student performance. Laws vary among the states that have passed charter school legislation, but usually the "organizers" can be almost anyone: parents, teachers, university officials or community people. The "sponsors" are typically local or state boards of education. The contract between the two groups spells out how the school will be run, what will be taught and how success will be measured. In some cases there are within-district charters that have been started by public school officials who want to allow some flexibility and creativity while they maintain ultimate control over the charter school and its budget.

Charter schools are a recent but rapidly spreading phenomenon. Since the first state (Minnesota) passed charter legislation in 1991, other states have continued to jump on the bandwagon. At the end of 1994, 11 states had charter legislation, and two years later there were 25 chartering states plus Washington, DC .

Legislation varies somewhat from state to state, so it's difficult to make generalizations about what charter schools can and can't do. Furthermore, the local founding groups and their reasons for seeking freedom from public school restrictions are diverse. Some charter schools are established to serve specific populations: "at-risk" students, specially talented students, children of parents who can volunteer large amounts of time and energy to getting a school started, etc. Thus the various objectives and natures of charters make for complicated appraisals.

Can We Determine if Charter Schools Are Effective?

Another source of difficulty for parents in making decisions about whether a charter school is a good place to send their children is ***evaluation***. Not only is the charter movement recent and thus lacking in data that indicate effectiveness, but school officials (both operators and sponsors) often don't seem to have a good idea of how to do meaningful evaluations. Some are measuring students' performance on standardized tests; some are looking at "portfolio assessments"; others are polling parent satisfaction; and still others are doing some combination of these. In 1995 the Education

Commission of the States and the University of Minnesota's Humphrey Institute collected some early survey data. However, in publishing the results, the authors Medler and Nathan, included a warning on the survey's limitations: only those respondents who chose to complete the survey forms are represented in the data, and many of the responses to questions about the future are sheer speculation by the charter school officials. (For information about the survey or to order a copy of the results, contact ECS at 707 17th St., Ste. 2700, Denver, CO 80202; (303) 299-3600.)

For most parents' decision-making purposes, there isn't much to go on. The short history of charter schools and the lack of data (or even of the knowledge about how to collect the data) mean that the jury is still out on whether they are effective.

Financial Issues

Finances are a major concern for charters in at least two respects: adequate funding and fiscal accountability. Finding enough money is one of the major obstacles faced by charter school founders. In spite of their promotion as an inexpensive method of improving education and providing choices for children in disadvantaged families or neighborhoods, charter schools require huge outlays for facilities and equipment, as well as for the increased staff that will allow for the smaller classes advertised by most charters. State formulas vary, but public funds for these schools generally depend directly on the number of students enrolled. For the school that is just getting started, there is no money for buildings or major equipment and no ability to raise money through bonds. Many charter schools are asking teachers to take salary cuts and to work longer hours, and most are employing uncertified teachers in some positions. Despite cuts and frugality, all charter officials report that finding sufficient funds remains a big problem.

Another major concern is accountability: whether the charter schools are fiscally responsible. One follower of the national charter movement, Louann Bierlein, has characterized state chartering laws along a continuum of "strength" vs. "weakness." Those states that have her definition of stronger laws allow the charters more autonomy in all areas, including use of and accounting for funds. Bierlein feels that strong laws allow charters to be more true to the fundamental concept for which they are established. Unfortunately, however, Arizona, the state which Bierlein rated as possessing the strongest legislation, has experienced several scandals related to charter founders' use of taxpayers' money. Other "strong legislation states" also provide examples of charter educators who either have been inept at budgetary matters or may be what Molnar calls "quick-buck operators," who are more interested in making money than in reforming education.

When is a Charter School Most Appropriate?

In relatively small, homogeneous districts that are showing at least minimal success in dealing with the usual educational problems, a charter school is less appropriate than in larger problem-riddled districts that serve a diverse population. For example, a charter school might be helpful in serving inner-city drop-outs or students who need small classes to help them overcome learning disabilities. However, when a district is making progress in setting standards, assessing students' progress and improving its curriculum and programs, a charter school would most likely divert attention and dollars from those efforts.

What if a Child Needs Special Education Services?

In their applications, many charter school officials have indicated that they will serve "at-risk" students. However, in actuality, most of them are not doing so. During the 1995-96 school year, only 4% of the approximately 7,000 students enrolled in Arizona charter schools were being served as special education students. That is considerably less than the national percentage (10 to 12%) of students who meet the criteria for special education in the public schools. Two-thirds of the schools that responded to the ECS survey stated that they were not designed to serve children with learning disabilities. However, children with handicaps have rights to an education without discrimination. Because of the expense of special needs services, schools and districts need to develop systems to ensure students with disabilities have meaningful access to support in charter schools.

How Can I Determine if a Charter School is Right for My Child?

- Read the charter school's literature and stated purposes carefully, looking for specifics of what the officials plan to accomplish and how they will measure progress toward those goals. Ask questions and seek written answers if specifics about your concerns are missing.
- Look at who is running the charter: are they responsible educators who have reputations for commitment and success, or is an unknown, "for-profit" business without a proven track record in education involved?
- Does the school have a reasonable budget and annual auditors' approval? Are the organizers of the charter school realistically facing the serious financial challenges faced by all such schools?
- What kinds of investment of time, energy and money are you as a parent expected to make? Is that acceptable to you?
- If your child has special needs, will those be accommodated?
- Do charter school students have access to district programs that may be important to your child, such as performing arts, team sports competition, library facilities, science labs, etc.?

Resources for Parents and Educators

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Home Schooling

A Handout for Parents

by Deanie R. Campbell, Camilla GA

Background

Homework for most children is a negative thing, but for a growing number of kids, *all* their schoolwork is *homework*. For many reasons, more and more parents are opting for home schooling. Some parents choose home schooling for religious reasons. Some parents feel that as a part of the school curriculum/environment, beliefs or values are promoted/tolerated that are in opposition to those taught in the home or church. For instance, some parents are opposed to the teaching of evolution, sex education or the reading of literature in which there is profanity and/or promiscuity.

For other parents, the decision to home school is fueled by the perception that schools cannot/do not meet the needs of all students; rather, schools teach to the "average" child. Particularly parents of children who are exceptional (perhaps due to giftedness or a handicapping condition) consider the option of educating their child(ren) themselves, knowing that the primary goal of their home school will be to provide an appropriate education for their child(ren).

Additionally the impersonalness and large numbers of students in a public school cause some parents to choose home schooling. Some parents simply cannot bear the thought that their child, number one to them, will be one of three hundred first graders in an elementary school of over a thousand students. Also, some children feel that they do not really count— they're one of 400 seventh graders; no one will even know if they are there. Large numbers of students in school also cause some parents to have security concerns. They fear for the safety of their children due to violence in the schools, e.g. gangs, bullying, sexual harassment.

Advantages

When deciding whether to utilize public/private/parochial schools or to home school, parents examine the advantages and disadvantages of home schooling. The foremost advantages of home schooling are flexibility and individualization. ***Flexibility*** is demonstrated through the ability to extend instruction when interest or the concept to be taught warrant extra time. At home school, the school day does not have to be regimented into artificial blocks/periods. Too, the school day does not have to begin at 8 a.m. and end at 3 p.m. The flexibility of home schooling also encompasses the ability to access and incorporate other resources , such as equipment/programs available at the local library; cultural events occurring at the local arts center, theaters, museums; learned/unique individuals within the community, such as retired persons who participated in historical events; etc. The flexibility also extends to the curriculum as the parents may choose from any number of published curricula or they may develop their own.

The ability to select and/or tailor the curriculum of the entire school for the child(ren) allows the ultimate in ***individualization***. There is no pressure to achieve a certain objective by a certain date regardless of the child's progress. All instruction derives from the needs of the student rather than from a school calendar, state mandate, school board policy, etc.

Another important advantage of home schooling is ***total parental involvement***. When the parent is the teacher, principal, custodian, school nurse, etc., there is no uncertainty as to what is really going on with your child at school. You, as the parent/educator, are totally involved and totally aware of what your child is working on, how he/she is progressing, what is coming ahead, etc.

Disadvantages

What then is the downside of home schooling? There are several disadvantages which must also be considered. Most opponents to home schooling cite as disadvantages: socialization, test scores and lack of opportunity (e.g. labs at high schools, etc.).

Socialization: It is true that children who are taught at home have less opportunity to interact with the number of students with whom they would have come into contact at a traditional school; however, in such schools, the structure of the school day provides small opportunity for true socialization and some of the interpersonal interactions that do occur may be negative in content. Also, the home student can become involved in outside activities through their church, home schooling organizations, athletics, scouting, etc., which allow opportunities for true socialization in a somewhat structured environment.

As far as ***test scores*** are concerned, some people expect that home students will lag behind traditionally schooled pupils. This has not been definitively proven; in fact there is research that suggests that home students do equally as well or better than traditionally schooled peers. Common sense suggests that home schooled students should outperform traditionally schooled peers due to variables which have been determined to positively affect student performance— pupil-teacher ratio and amount of time for individual instruction.

Limited opportunities: While the third most often mentioned disadvantage does have some validity, as most homes do not have access to well-equipped laboratories for the teaching of chemistry, biology, or physics for example, this is not an insurmountable obstacle. In fact, some states— Alaska, California, Idaho, and Iowa— allow home schooled pupils access to public school classrooms. In states or school districts where there is less cooperation, parents have the option of working out collaborative arrangements with businesses, purchasing rudimentary lab supplies and making do, establishing agreements with nearby colleges, etc.

Transition to college: Rarely mentioned, but necessary for consideration, is the concern that a child will go from a high school of one (at home) to a college of thousands or tens of thousands. Parents must consider whether the child will be eligible to enter the college/institution of their choice coming from a home school environment and whether this will place extreme limitations on the child's eligibility for scholarships.

Problems for parents: Parents must be careful not to overlook the disadvantages of home schooling which impact them more than the child. For instance, whichever parent is to provide the instruction must consider that this arrangement can be somewhat confining and will require a great deal of commitment on his/her part. This may also necessitate the loss of income as the parent/ educator may have to cease work outside the home or lessen the number of hours at work.

Considerations

Regulations: While contemplating the option of home schooling, parents should contact their state's Department of Education and ask for complete home schooling regulations and also ask for any support groups/services available within the state. Regulations vary from state to state, but most require a Letter of Intent stating the name(s) and age(s) of the child(ren) who are to be taught at home. Some require that attendance be kept, that children participate in standardized testing, etc. Parents should thoroughly read through and examine their state's regulations and make sure that they can abide by all regulations if choosing to home school.

Curriculum: Once the decision has been made to utilize home schooling, the next decision is what will be taught at the home school. There are many published curricula which serve different aims. A Beka is a widely known and used curriculum that provides daily religious instruction. The Calvert School curriculum provides a more classical instruction teaching world history, art education, etc., from Kindergarten forward. There are also curricula, lesson plans and instruction available online via your computer, as well as magazines and newsletters for home schoolers which provide information about conventions and conferences about home schooling. The choice of a curriculum should be based, at least in part, on the primary aim of home schooling.

Structure: To be successful at home schooling, there needs to be some structure and some involvement from the children. Children can be involved in developing a basic schedule to be used (for those days in which nothing special, e.g., a trip to the museum, is planned). For parents who have not taught school or have not worked with children the age of those they are going to teach, some assistance (through books, talking with teachers or experienced mothers) is needed to help design a schedule and instruction that is age appropriate. For example, instruction lasting over an hour with no break is inappropriate for elementary aged children; expecting well-developed fine motor control in these young children, especially boys, is also unrealistic. It may be helpful to allow the child(ren) to create a name for the home school (e.g. Pebble City Elementary).

Resources

Guterson, D. (1992). *Family matters: Why home schooling makes sense.* Harcourt, Brace, and Jovanovich.

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Homework Survival Guide

A Parent Handout

by Peg Dawson, Ed.D., NCSP
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A Place to Work

1. Find the right place.

In some families, having a central location where all children in the family do their homework works best. This may be the dining room or kitchen table. In other families, each child has her own study place, usually at a desk in the bedroom. What works for you depends on your children. Some kids do best under the watchful eye of a parent in which case the dining room or kitchen may work best. Others need the quiet of their bedrooms to avoid distractions. Some kids like to work with the radio on (and this helps them focus), while other do worse with this kind of background noise. Think about possible distractions that will need to be avoided (a nearby television, the telephone, etc.) when planning your child's workspace.

You may want to conduct "experiments" with your child to determine what setting works best under what circumstances. Try several options for a week to see how your child does (rate the quality of the homework completed, the time it took to finish, and the child's subjective reaction).

2. Gather necessary materials.

Youngsters can waste a lot of time tracking down things like pencils, paper, rulers, etc. when beginning their homework. To avoid this, stock your child's study area with these materials and any other he is likely to need, such as a dictionary, highlighters, pens, scissors, glue, tape, colored pencils, stapler and staples, etc.

It may also be helpful to set up file folders for each subject your child is taking in school to keep track of necessary papers, such as long-term assignment directions, tests and homework that have been passed back (to help in studying for the next test), etc. These folders should *not* be used for storing homework, since your child is likely to leave it at home and forget to take it to school. Completed homework should be placed in the child's backpack, trapper keeper, or notebook as soon as it is finished to ensure it gets to school.

A plastic bin may be an ideal place to store study materials; if you have more than one child, you may want to have one bin for each child. The advantage to this is that these are portable — just in case you have a child whose preferred study style is to work in a different place each night!

You may also want to have a second container (such as a dishpan) which your child can "dump" their school things in as soon as they get home from school. This will help avoid last minute frantic searches for permission slips, library books, messages from the principal, notices of meetings, etc.

Organizing Homework/Setting Priorities

A homework session should begin by reviewing what the day's assignments are. It is probably a good idea to draw up a list of assignments on a separate sheet of paper, so that you can then help your child prioritize and break down longer tasks into shorter ones. The steps to follow might be:

1. List out assignments.
2. Make sure the child brought home the necessary books, worksheets, etc.
3. Break tasks into subtasks.
4. Check to see what other tasks the child has to do which should be included on the list — including long-term assignments, and tests later in the week for which the child should begin studying. Add these to the homework list.

5. Have the child decide what order she will complete the work. A good rule of thumb is to have the child begin and end with assignments she considers "easy," sandwiching more difficult assignments in between.
6. Estimate how much time it will take to complete the work.
7. Make sure you have allowed enough time for the child to complete all his homework, allowing for break time as necessary.

Sometimes it is difficult for kids to complete homework because of other obligations they may have — sports events, doctors' appointments, scout meetings, chores, family events, etc. You may find it helpful to put together a weekly calendar to keep track of these activities. A sample of such a weekly calendar is contained in Appendix A. Once a week (Sunday sounds good), sit down with your child and fill out the weekly calendar together. Then, as you plan your homework time each day, you can reference this calendar to allow time for the other activities your child is involved with.

Getting Started

As mentioned above, it is usually best to have children begin with a task that they consider "easy." Some children may want to start with the hardest task first to get it over with, and this is acceptable unless the child has a very difficult time getting started and will dawdle or avoid the difficult assignment even though it was his/her choice to start with it.

For many youngsters, just getting started on homework seems like an insurmountable obstacle. We have several suggestions for handling this problem:

1. Have the child specify exactly *when* she will begin her homework and then reward her for getting to work within five minutes of the time she has specified (see the section on Incentive Systems for more information about this).
2. Sit with your child for the first five minutes to make sure he gets off to a good start.
3. Talk with your child about her assignments before beginning. This is particularly important for written language assignments or more open-ended tasks. Children often need to be "primed" or activated for the best efforts to come out. This is particularly true for youngsters who may have difficulties with verbal fluency or word retrieval.
4. Orient your child to his assignment; walk him through the first one or two problems or items to make sure he understands what he is supposed to do.
5. Build in a short break relatively quickly, if getting started is a problem.

Getting Through It

Make sure adequate breaks are built in. Many children have a great deal of difficulty working for long stretches of time on homework without a break. Better to plan for a two-hour homework session with frequent breaks built in than to try to cram homework into a one-hour, non-stop session. You can use a kitchen timer to keep breaks to a reasonable length (e.g., 5-10 minutes). Breaks might be used to get a snack, play a few minutes of a Nintendo game, or to shoot baskets or do some other form of exercise. Breaks should be scheduled when tasks get accomplished rather than after a set period of time, otherwise your child can daydream the time away and still get a break.

One child we know arranges homework sessions between TV shows he likes to watch. Thus, his schedule on any given day might look like this:

4:30	Math	6:30	Social studies
5:00	TV show	7:00	TV show
5:30	English	8:00	Science
6:00	Dinner	8:30	TV show

If he hasn't finished whatever task he was working on when his television program comes on, he either misses the program or tapes it to watch at a later time.

Other suggestions for getting through homework:

1. Make a game out of work completion: have the child estimate how long it will take to complete an assignment, have her "place bets," set a kitchen timer where the child can't see how much time it was set for and challenge her to "beat the clock," or use a stopwatch to see how quickly she can do an assignment, one math problem, etc.
2. If a task takes longer than your child can sustain (even if it's broken down into smaller steps), or if he "gets stuck," have him switch to another assignment rather than stop working altogether.
3. Use a "beep tape" to help him stay focused. This is an audio tape which sounds an electronic tone at random intervals. When the child hears the tone, she is to ask herself, "Was I paying attention?" She can be given a form to fill out to accompany the tape. This has been quite effective with children who daydream or who get pulled off task easily, often without even realizing it. The tone brings them back to task. Alternatively, some parents make "nag tapes" where they tape messages at random intervals, again to prompt the child back to task.

Long Term Assignments

These are often the hardest homework assignments for youngsters to keep track of and to complete.

1. Know what assignments are due when.

In addition to having a weekly assignment book where daily homework is recorded, it is also advisable to have a monthly calendar on which long-term assignments can be written as soon as they are assigned. With younger or more disorganized students, parents may want to periodically send in this calendar and ask the classroom teacher to verify that it is up-to-date. Older students should be able to keep these themselves, transferring items as necessary from their weekly assignment book.

2. Break long-term assignments into subtasks.

Sit down with your child and read over directions or discuss the nature of the long-term assignment. Make out a list of the steps necessary to complete the assignment. If desired, this can be a fairly lengthy outline with notes attached providing more guidance about what is to be included for each step. For written reports, for instance, the steps might include taking notes, generating an outline, writing the introduction, the sections of the report and the summary, preparing a bibliography, drawing any necessary maps and charts, proofreading, preparing the final draft, and making a cover.

3. Draw up a timeline.

Once the outline is developed, each subtask should then have a due date attached to it and should be written on the monthly calendar. An example of this is included in Appendix A.

Care should be taken to ensure adequate time is available for each step. A long report will require that more time be devoted to each step, particularly preparing the final draft and proofreading. If the long-term assignment requires that your child use the library, visit a museum, or gather information from outside sources, include these trips in the timeline, with dates attached. If materials need to be purchased, the time when this will happen should also be identified.

In the beginning, your child will probably need extensive help breaking down his assignments and developing a realistic timeline. As time goes on, he can assume increasing amounts of responsibility for these. Time management is a skill of life-long importance. Developing increasing independence in planning for and executing long-term assignments is an early opportunity for a child to acquire this valuable skill.

Incentive Systems

For many youngsters, homework is an exceedingly difficult task representing an ordeal they perceive at times to be insurmountable. For these children, all the organization and planning in the world may not be enough to get them through the daily grind of homework. In this case, an incentive system may need to be put in place to make homework completion a more attractive task for them.

If this is the right approach for your child, we recommend a system whereby your child can earn points for completing tasks or for demonstrating other appropriate behaviors required for successful homework completion. The points can then be traded-in for daily, weekly, or long-term reinforcers. Steps involved in setting up a point system include:

1. With your child, draw up a list of privileges or rewards your child would like to earn. Daily rewards might include an extra half hour of television, a special snack, the chance to stay up an extra half hour before bed. Weekly rewards might include a trip to the mall or McDonald's, or the chance to go to a video arcade or rent a video. Longer term rewards might be going to a movie with a friend, inviting a friend over for the night, or the chance to buy a small toy.
2. Now, again with your child, draw up a list of "jobs" for which your child can earn points. Related to homework, such jobs might include:
   - Writing down homework assignments:
   - Bringing home necessary homework materials.
   - Getting homework started on time.
   - Completing work within the specified homework time.
   - Finishing homework without reminders (nags) from parents.
   - Finishing homework without constant parental supervision or assistance.
   - Completing work with an acceptable standard of accuracy.
   - Proofreading written work/checking math problems.
   - Handing in homework completed and on time.
   - Successfully solving homework problems (e.g., calling friends or teacher when an assignment is not understood, knowing what to do when books or other necessary papers were left at school, discussing homework problems with the teacher or going to the teacher for extra help).
3. Decide how many points each of the homework "jobs" can earn and how much each of the privileges or rewards will cost. To determine how much the rewards should cost, add up the number of points you feel your child will earn each day. Be sure that your child has about one third of her points free to save up for special privileges.
4. Get a notebook, and set it up with five columns, one each for the date, the item, deposits, withdrawals, and the running balance.
5. Once a month or so, review the list of jobs and privileges and revise as necessary.

Described above is a fairly elaborate system that may be necessary with those children who are highly resistant to doing homework. Samples of two homework reward systems are included in Appendix B. When the problem is not considered to be so extreme, a more informal system (such as the opportunity to earn a small reward after all the homework is done each day) may be all that is necessary. Children can also be taught to reward themselves as they complete tasks, both major and minor ones. they can also adjust the reward depending on the size or difficulty of the task: half an hour of reading is worth a 10-minute break to shoot baskets; completing a term paper is worth a bike ride to the store to buy a favorite snack.

With some children, the use of natural or logical consequences alone may be sufficient. Not being able to watch a favorite TV program because the homework wasn't done in time is a logical consequence that arises from dawdling over assignments. For some children, a failing grade is a natural consequence for failure to complete homework, and this alone will be sufficient to induce them to work. However, it has been our experience that parents should not assume that fear of a failing grade alone will be sufficient to induce their child to do his homework.

Parents should resist the temptation simply to punish children for their failure to do homework. While it may make sense to cut down on the number of outside activities or the amount of time their child is allowed to play with friends after school in order to allow for sufficient time to do homework, a system in which incentives are built in for homework completion will likely be more effective than a system of negative consequences alone. Most children who have problems doing homework are not happy about their situation or the fights they draw their parents into. Rather, it seems to take these children considerably more effort to get down to work and to sustain attention to homework than it does the average child. For this reason, it makes sense to reward them for the extra effort it takes.

Parent Role: Help or Supervise?

Many parents, particularly those of children who may be struggling in school, wrestle with the question of how much help they should give their children on homework. The following suggestions are offered:

1. It is a good idea for parents to discuss with their children the nature of the assignment, to make sure they understand what they are supposed to do, and to guide them as they do the first one or two items of an assignment. Parents should not have to remain by their children's side throughout the entire session. If your child seems to require this, then you should probably build in an incentive for working independently to wean your child of reliance on you for support or assistance. Setting the kitchen timer and telling your child to wait until it rings to show you her work or to ask questions is one way to gradually increase independence.
2. Parents may want to review homework assignments to check for either neatness or accuracy. If the handwriting is illegible (and your child is capable of writing more neatly without an inordinate amount of effort), it is acceptable to ask him to rewrite the assignment. If your child is ready to learn to proofread or to check for mistakes himself, you may want to hand back a paper back with a comment such as, "I found three mistakes on your math page," or "Please look for spelling errors." If he's not ready for this, point to the specific mistakes and ask him to correct them (without giving him the correct answer).
3. Parents should keep in mind the overall purpose of homework: to give children independent practice with a skill they have already been taught. Parents should not have to teach the skills necessary for their children to complete their homework successfully. A good rule of thumb is that children should be able to get at lest 70 percent of a homework assignment correct working *on their own* for it to be within an appropriate instructional range. If your child cannot achieve that level of success without a great deal of support from you, then the homework she is being assigned is probably inappropriate. Make an appointment with your child's teacher to ask for assignments that will better give her the practice she needs.
4. You may also want to talk to the teacher if your child appears to be spending an inordinate amount of time on homework even though he is successful at it. Ask the teacher how much time a child should be spending on homework, and if you child is working much more than that, ask for an adjustment in workload, such as reduced assignments.

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Appendix A: Organization Aids

Weekly Calendar

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Assignments							
Chores							
Activities							
Other							

Sample Calendar for Planning Long-term Assignments

APRIL						
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					1 Good Friday	2
3 Easter	4 Choose topic for report	5 Find books at library	6 Take notes	7 Take notes	8	9 Make outline
10	11 Write introduction	12	13 DRAFT: write 1st half of report	14 DRAFT: write 2nd half of report	15	16 Make charts, map and cover
17	18 Make bibliography	19 Revise report	20 Do final draft	21 Proof final draft	22	23 Make final corrections
24	25 Report due	26	27	28	29	30

Appendix B: Homework Contracts

Sample Homework Contract I

Terms of Contract:

1. John will write down all assignments in assignment book.
2. The daily TV schedule will be:
   a. John can watch Batman at 5 o'clock.
   b. In order to watch any evening TV shows, homework will be completed.
   c. If homework isn't done, we will tape shows for later viewing.
3. John will not be allowed to play video games during the week unless all his homework is done. He can play no more than one hour per day at any time (including weekends).
4. On Fridays, John will have teachers sign a sheet indicating he has turned in all homework assignments for the week.

Points can be earned for:	***Point Value***
1. Handing in all homework assignments for all classes each week	5
2. Grade of B or better on quizzes or tests	3
3. Grade of B or better on a report or project	5
4. Grade of B or better on report card (academic subjects)	5
Points can be traded for:	
1. A contribution to the Super Nintendo fund — $30	120

Sample Homework Contract II

Daily Homework Tasks	***Points***
All assignments written down	1
All materials brought home	1
Finish homework by 9 PM	1

Privileges	***Cost***
DAILY	
Extra half hour TV show	3
Extra snack	3
Practice soccer with dad	3
15 minutes video game time	3
WEEKLY	
Rent a video game	12
Rent a movie	12
Have a friend sleep over	12
Go to Friendly's for ice cream	15
LONG TERM	
Eat at a Chinese restaurant	75
Take a friend to a movie	75
Go bowling	75
Earn a new cassette tape	75

POINT TRACKING SHEET

Date	Item	Deposit	Withdrawal	Account Balance

National Association of School Psychologists

Organizational Skills for Children

A Handout for Parents

by Gail Epstein Mengel, Ph.D., NCSP
Longmeadow, MA Public Schools

Background

The ability to get organized is frequently taken for granted. Unfortunately, when children are disorganize, their resulting failure is often blamed on laziness, lack of motivation, irresponsibility, procrastination or avoidance. The opposite is typically the case, however. Rather than being the result of a motivational problem, disorganization is more often the cause of it. Whether the task is organizing spaces, materials, information or procedures, weak organizational skills can be a genuine obstacle to learning and performance and can also deflate motivational energy. Weak organizational skills can cause failure among bright children and fuel emotional distress in emotionally healthy children. When the problem is understood, however, disorganized children can be "coached" rather than pressured to improve through the efforts of parents and teachers.

Development

Disorganization in children is a common classroom concern. Disorganization has been identified as one of several key characteristics of an Attention Deficit Hyperactivity Disorder (ADHD), but it also been recognized as a hallmark of a "nonverbal learning disability" or a learning style difference. To parents, learning that their child's disorganization is not willful or the result of a motivational problem brings a sense of relief and, hopefully, empathy and understanding for their child's plight. Some telltale clues in children's present or past development can help to distinguish between the child who is disorganized primarily because of motivational or emotional factors and the child who is disorganized because of learning style differences.

Learning style differences: Tip-offs to learning style differences include having had early childhood trouble with concepts of place and time (such as above, below, left and right; before, after, tomorrow, yesterday). As these children enter school age, rote learning of sequenced information (for example, learning the months of the year), learning how to tell time, following sequenced directions and learning routines, procedures and schedules are difficult for them. Knowing where to start, what to do next, planning, prioritizing, scheduling, completing multiple step tasks and long-term assignments, anticipating consequences (if-then), predicting outcomes, using time efficiently and effectively and making transitions easily are all related to time concept learning that become more important as children get into the mid to late elementary grades.

Weaker concepts of space and place may show themselves early through disinterest in jigsaw puzzles, immaturity in drawing skills, and a weaker sense for where to position the body in space. Elementary school difficulties show up most often in writing: Handwriting may be illegible, poorly spaced, uneven in size and slant, and "floating" on the lines. Columns may waver. Reversals may persist. Written expression may be poor because the child is concentrating so hard on pencil movement that the focus on the thoughts being expressed is reduced.

Math is often a challenge. In early grades, misaligning columns can easily undermine the young mathematician whose answers then do not make sense. Carrying and borrowing ("regrouping") and part-whole relationships (decimals, fractions, percentages) can be particularly mystifying to disorganized children.

Organizing thoughts in a cogent and coherent manner and remaining focused on the point of a lesson can be a real challenge. All too often, the information disorganized children take in through their senses seems to defy being sorted, classified, categorized and sequenced in meaningful or logical ways. They often fail to see the patterns and routines of simple procedures or everyday events or to see the important from the less important details to prioritize. They can become easily confused and sometimes disoriented in space and time. In a very real sense, they are frequently unsure of "which end is up." Histories of accident-proneness and clumsy coordination are not untypical of the very disorganized child. It is no wonder that they do not want to take a risk to try, without some reassurance that they might succeed.

What Can I Do as a Parent?

It may well be a natural reaction to tell disorganized children that they must "get their act together." However, this approach—without coaching them in the specific ways to do this—can create more frustration, hopelessness, avoidance and resentment. In fact, pressure, threat and emotionally charged reactions can actually "shut down" the disorganized child and undermine our attempts to incite them to action. Because of this, it becomes important to recognize that how we teach the disorganized child is almost as important as what is taught. A style that remains patient, neutral and guiding works best to offer stepping stones to cross the stream to independence.

Helping disorganized children to gain a greater sense of control over their lives is an important part of this approach. Without a sense that they can overcome and control the disorganization, they are less likely to develop the internal motivation to get organized. Coaching them in breaking down tasks, using strategies, making decisions and increasing awareness of their thinking processes helps provide this sense of control. Although additional strategies may be needed depending on how the child's problems impact performance, there are some common approaches to address disorganization that can be applied to all learners.

Teach how to break down the task. Doing a long term assignment (book report, project or paper) is an overwhelming task that lends itself to this breaking down process. This can be broken first into major steps such as (a) choosing the topic, (b) locating the books and materials for research, (c) taking notes on index cards, (d) writing the first draft, etc. Minor steps also need to be identified, however, such as arranging the ride to the library, buying the index cards, etc. When the larger task is broken down into its smaller "bite-sized" steps, parts, categories or sections like this, each individual part becomes more approachable, and encourages interest in trying.

Another example of how tasks can (and need to) be broken down further is found in the homework process. "Smashing the task"—into its bits and pieces—brings to light new understandings of where the process may be going wrong. "Getting your homework in" might break down into (a) writing it into an assignment notebook—accurately; (b) locating and bringing home the right materials to complete it; (c) planning the time to do it; (d) doing it; (e) putting it back into a "return to school" spot; and (f) handing it in at school. The task then becomes one of strategizing (see below) to address the specific step that breaks down and brainstorming possible ways to "fix" it. At this point seek to create systems, strategies, routines and checklists to help mend this breakdown.

Teach strategies. Strategies are techniques that help to get the job done more easily, quickly and/or better. They can be merely effort-saving shortcuts or thoughtfully devised plans. Often they involve using "props." *"To Do" checklists* are key props for organizing. They give an immediate sense of accomplishment because they show visible progress with each check-off that marks completion of a step. *Watches with a stopwatch function* entice kids to actively time how long it takes to finish various tasks (including homework and organizational chores) and assists their ability to plan for these activities. *After-school time schedules* help kids "see" time in visual blocks. *Mapping* their obligations and commitments onto this schedule and choosing the time blocks for homework encourages children to make decisions and further increases their consciousness of time and planning skills.

Using *60-minute timers* to have a "race against time" for mundane tasks—such as getting ready for school in the morning or cleaning up a room—helps make a game out of the job, and makes it more positive if linked with a privilege or reward for meeting the deadline. *Plotting* the steps of a long term assignment onto a monthly calendar with even smaller steps broken out for daily assignments helps finish the job with less "last minute" panic.

Writing a set of *criteria to guide action* helps make decisions clearer and easier to make. A prime application of this for the disorganized child is knowing what to "stash" and what to "trash." With clear rules governing this decision, unnecessary clutter is more easily weeded from binders and desks. Using *hard- sided containers* of all sorts—crates, bins, cans, file folders, etc.—and labeling them with words and perhaps pictures as well—helps "grease the skids" for getting things to their rightful places and makes it easier to find them. *Color-coding* highlights groups or patterns, and gives a quicker overall sense of the organization within. When a class subject's separator tabs in the three-ring binder are also coordinated in color with the class' bookcovers' colors and the subject is colorized on the class schedule, retrieval of materials for class and for homework is made easier.

Allow room for decision-making. Disorganized children are frequently indecisive. They have messy desks and notebooks because they cannot decide what to keep and what to throw away (they need criteria). They do not do their work because they cannot decide where to start and what to do next. Organizing involves taking control over time, procedures and materials. Taking control requires making decisions. This can be "coached" in several ways:

Give choices appropriate to their age (all of which they can feel safe in making since the adult provides the alternatives from which to choose). Over-structuring children by eliminating choices undercuts their confidence in their ability to make decisions for themselves. *Gently coach* by your questions rather than tell the answers to every question. *Raise awareness* of making decisions by your comments ("Good decision," "That choice means you'll be able to..."). Draw *decision "trees"* to illustrate choices and their outcomes ("If I do it this way, then x will happen. If I do it that way, then y will happen."). *Model out loud* how you are deciding upon an issue so they can see the inner language script you use. Show them how to develop *lists of pros and cons* to help their decisions become more obvious. Help them to narrow down the choices by eliminating the least desirable choices first and working backwards.

Raise their consciousness of their active thinking. Disorganized children often are accustomed to having things done for them because adults cannot wait for them to get the job done. However, when they learn not to think and do for themselves, they become less mindful of what they have left behind or forgotten, misplaced, or failed to do. Approach them in a positive way to reinforce thinking behaviors. Use specific "thinking" words to highlight instances of self-awareness and self-direction: "You remembered (to put your homework in your backpack)," "You noticed (that you didn't put the heading on your paper)," "You caught yourself (getting distracted)," "You realized (your library book was due today)," "You recognized (you almost left out that word in the sentence)," "You thought about it," "Good plan," "You used a strategy," etc., all are ways to affirm thinking for themselves.

Summary

Disorganized children are a challenge to the adults with whom they work. They need our patience and step-by-step management so that they can see the distinct parts and steps of each task. To threaten them can unravel them. To overwhelm them can immobilize them. Yet to rush to rescue them can undermine their self-confidence in their ability to take charge of their lives. A more promising approach is to coach them by slowly and gradually building upon their progress and appreciating each step they take toward independence. Empathy, understanding, teamwork and communication between parents, school and child greatly assist in this process.

Resources

Mengel, G.E. (1991). *The homework organizer: Assignment notebook and guide.* (Get Organized! 8 Sunrise Circle, South Hadley, MA 01075.) This assignment notebook breaks down the homework process into its smaller steps and provides step-by-step instruction for long term assignments, time planning and other organizational tasks of the school day.

Smith, S.L. (1995). *No easy answers: The Learning Disabled child at home and at school.* Bantam Books. Detailed yet untechnical and highly readable, this book gives excellent insights and practical approaches for parenting a child who is disorganized.

Winston, S. (1978). *Getting organized.* Warner Books. Provides practical, step-by-step methods for physically organizing all aspects of personal living including time management, setting up and reorganizing a desk, organizing storage, and helping children's personal organization.

Appreciation is expressed to Kathy Gibson, school psychology student at the University of South Florida, for her review of this handout.

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Parent–Teacher Meetings

Dos and Don'ts

by Marcia Weill,
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Unified School District

DO:

- Make the first contact a positive one.
- Just before the conference begins, calm yourself, visualize the student, recall his strengths, prioritize any concerns, empathize with parents.
- Understand and enjoy differences. Determine need for translators.
- Be accessible. Remove physical barriers. Use positive listening, non-defensive body language.
- Assume parents know child best. You share the common goal of student growth.
- Use specific examples and everyday language. Describe behavior objectively.
- Listen—then give a few practical suggestions.
- Maintain confidentiality.
- Model teamwork in respectful cooperation with other educators.
- Conclude the meeting with hope, with the parents' believing that you know and respect their child and have a plan.

DO NOT EVER:

- Make the first contact be bad news or a big meeting.
- Talk down to or judge parents' decisions. Assume the parents are not distressed because they appear strong.
- Rely on disability, social, economic or cultural stereotypes.
- Sit behind your desk, eat or drink without providing for everyone present.
- Be an expert. Make unfounded predictions.
- Use jargon or subjective and emotionally-loaded terms.
- Talk too much. Make parents feel inadequate when they can't do what you suggest.
- Use names of other students.
- Disagree with school staff in parents' presence.
- Leave a parent feeling hopeless or that financial or staffing concerns will interfere with meeting their child's individual needs.

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Psychological Evaluations

Choices for Parents

by Thelma Alpert Blumberg, NCSP
Baltimore City Schools

Background

When children's academic failure or improper school behaviors are reported, it is not unusual that parents feel apprehensive. Moreover, when psychological evaluations are suggested, parents may become overwhelmed. Concerns can develop about unnecessary labeling or about invasion of privacy by school personnel. In fact, some parents panic and imagine that their child may be labeled 'crazy,' moved to a special school, or expelled from the school system altogether.

Questions for the parent then arise about whether to permit their child to be tested at the school, or to seek outside evaluations. Clarification of the different features offered by school psychological services and by outside agencies may help parents when they are faced with making these choices.

Facts about Psychological Evaluations

The assessment procedures used by either the school psychologist or by an outside psychologist are basically the same. There are two major types of measurements. When academic performance appears as the primary concern, psychologists usually use tests which measure intellectual ability as well as tests of achievement in basic subjects such as reading and math. When social/emotional behaviors appear as major concerns, an assessment of emotional status may be included.

Intellectual evaluation: Assessing intellectual abilities is more complex than the mere search for an IQ score. It involves formal tests which usually reveal these primary features: profiles of intellectual strengths and weaknesses; unique learning styles; factors that interfere with learning; and strategies for improving academic performance.

Social-emotional evaluation: Some of information gained from assessing social and emotional status includes: how well children relate with peers and adults; level of self concept; ruling out conditions such as depression, phobias and thought disorders. Materials used here may include background history, student interviews, parent and teacher conferences, classroom observations, tests which explore thoughts, feelings and moods, and behavior checklists.

Outside Evaluations: Advantages

- ***Rule out medical problems:*** It is sometimes necessary to rule out seizure disorders, lead poisoning, organic syndromes, or other psychiatric and medical conditions. Obviously schools are not equipped to do these evaluations. A major convenience of outside clinics is that these specialists, along with psychologists, may all be housed at the same location.
- ***Availability of specialists:*** When the disabilities suspected are of a critical nature, a coordinated diagnosis may be especially beneficial for the parent. Conversely, visiting many specialists at different locations may prove to be a chaotic, baffling experience for the parent and the child. When a child's condition requires medical expertise, prescribed medication, or specialized counseling, these services are usually available at the outside clinic.
- ***Working with school personnel:*** Some clinics send representatives to team meetings held at schools, offering information, advice and support for the child, parent and the school.

School-based Psychologists' Evaluations: Advantages

- ***Accessibility:*** Because the school psychologist services your child's school on a regular basis, this accessibility affords special advantages. The school psychologist may observe classes, examine the child's school history and consult and intervene with school staff members. These features add depth while clarifying your child's special needs.
- ***Mandated timelines:*** There are legal timelines regarding evaluations which must be followed by the school, and which dictate the speed with which obtaining assessments and special services are obtained. Inasmuch as outside evaluators are not bound by these guidelines, their delay with an assessment may interfere with the speed with which critical school services are provided.
- ***Relevance to school planning:*** There are legal guidelines for report writing, too, which are always required for special placements. School psychologists receive ongoing instruction relevant to guidelines. As this training is not always required of service providers at outside clinics, some of their evaluations lack vital information necessary for the school to make an appropriate educational plan.
- ***Familiarity:*** Most children are more comfortable when evaluated at their local schools. It is quite a natural and often enjoyable process to be taken out of the classroom, to a familiar part of the building, by a person who is known by the child.
- ***Flexible scheduling:*** When a child is referred for more than one evaluation, such as psychological, educational and speech/language, the school can easily administer each on a different day. Scheduling many tests for one day, as most clinics do, can exhaust a child.

What Other Services Can the School Offer?

- ***Pre-referral consultations:*** Your child may have a problem that can be easily remedied without formal evaluations. School psychologists and other specialists are usually available at all schools for pre-referral consultations.
- ***Child advocate:*** The school psychologist , social worker or counselor at your child's school is available to serve as your child's advocate, for as long as the need is present, whether your child has been referred for consultation or assessment.
- ***Parent advocate:*** At any stage of the evaluation process, a school psychologist, social worker or counselor may be available to serve as the parent advocate, regardless of where your child is evaluated.
- ***Other services:*** Your school psychologist, social worker, counselor and other specialists can advise you about programs offered at schools, for children with special needs. These may include physical, occupational and speech/language therapy, along with services for children with visual, auditory, orthopedic and other impairments.

Suggestions for Parents

- ***When it is necessary to rule out other factors:*** If there are suspicions that your child may have special medical concerns which need to be explored, in addition to school problems, inquiry at a comprehensive clinic may be beneficial.
- ***Share information:*** Whether you prefer to have your child evaluated at school, or at an outside clinic, it is to your child's advantage that you share information about any prior evaluations. Failure to do so can interfere with treating your child's needs. In addition, repeated use of psychological tests reduces their value.
- ***Post-evaluation conferences:*** Every parent is entitled to a private, confidential conference with the psychologist (or other personnel) who has evaluated their child. If this has not been offered either at the school or clinic, do not hesitate to make such a request.

- ***Exploratory conferences:*** When you have questions, take advantage of the accessibility of your school psychologist and other specialists and schedule a conference, regardless of where you decide to have your child evaluated. You may be pleasantly surprised to learn that your greatest fears are mostly unfounded.
- ***Trust your evaluator:*** You and your child will benefit most from an evaluation when you are best informed and have trust in the professionals involved.

Resources for Parents

Blumberg, T. A. (1987). Parent counseling and training. In M. M. Esterson & L. F. Bluth (Eds.), *Related services for handicapped children* (pp. 69-71). Boston: Little Brown and Company.

Gellman, E. (1995). *School testing: What parents and educators need to know.* Westport, CT: Praeger.

Lyman, H.R. (1991). *Test scores and what they mean.* Prentice-Hall.

Martin, M,. & Waltman-Greenwood, C., Eds. (1995). *Solve your child's school-related problems.* New York: HarperPerenniel.

Shore, M., Brice, P. & Love, B. (1996). When your child needs testing: What parents, teachers and other helpers need to know about psychological testing. *Cross Timbers.*

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Psychological Tests
A Handout for Parents

Adapted by Andrea Canter, Ph.D., NCSP, (Minneapolis Schools) from *Solve Your Child's School-Related Problems*, (Harper Perenniel)

Overview

When their child is referred for a "psychological evaluation," parents may be upset, confused or worried. It is important to remember that a referral to a psychologist for an evaluation merely means that you or your child's teachers need more information in order to better understand how to help him or her achieve success at home or at school. If your child is referred to a school psychologist for testing at school, you must give your permission before any testing can begin. It is important that parents understand *why* testing is requested, *what areas of learning and development* will be addressed by testing, *what types of tests* will be given and by whom, and *how the test results will be used* to help your child. You may be invited by the school to a conference to discuss the referral or you may request a meeting with the teacher, psychologist and other personnel. You and your child will benefit most from testing if you feel fully informed and trust the professionals involved.

Parents sometimes worry that their child will react negatively or fearfully to testing. If you are comfortable with the testing plan, you will be able to convey your comfort and support to your child. Most children actually enjoy the individual attention they receive through testing, and many find the tasks to be fun and challenging. Children who tend to be wary of new situations will perform better if they have a chance to meet the psychologist prior to formal testing, and if they have a chance to discuss the reasons for testing and expectations for their performance. Children need to understand that parents and teachers only expect them to "do the best you can" and that they can not "fail" these tests.

What Kinds of Tests Will Be Given to My Child?

A good psychological evaluation uses several different methods to obtain information about your child, rather than relying on *one* test or *only* tests. Procedures may include observations in the classroom, information from teachers, parents and school or health records, as well as specific tests. Tests generally can be categorized as follows:

1. **Screening versus diagnostic tests:** *Screening* tests are brief and help provide a general picture of a student's skills or behavior but do not provide in-depth information. They are used to determine if additional testing in a given area is needed. *Diagnostic* tests are longer and provide more detailed information about a specific area, such as intelligence or reading or behavior problems. These are used to determine specifically how well your child performs, where your child is having difficulty and what instruction or support is needed to help your child.
2. **Norm-referenced versus criterion-referenced tests:** *Norm-referenced* tests compare your child to other children of the same age or grade level, usually on a national or regional level. Results indicate how far above or below "average" your child is functioning in a given skill or behavioral area. Most norm-referenced tests used by psychologists are "standardized" — they have been commercially developed using large numbers of children and are administered and scored in a standard fashion to assure consistency in results. The "norm" (point of reference) used is based on the population of students used by the test publisher to develop the test and to determine how typical children perform. *Criterion-referenced* tests compare your child's skills to a specific level of performance — they measure what has been learned. For example, in testing math skills, a

criterion-referenced test might identify how many basic math facts 1-10 your child has learned. There are many published criterion-referenced tests, but teachers and others will often develop such tests based on the materials they use for instruction in their classrooms.

What Tests Will The Psychologist Give to My Child?

Psychologists use a variety of tests which most often are diagnostic and which may be either norm-referenced or criterion-referenced. The most common types of psychological tests include:

- **Intelligence tests:** Popularly called "IQ" tests, intelligence tests are norm-referenced, standardized, diagnostic tools which very broadly measure traits which predict academic success. There are many different theories and definitions of "intelligence," but the tests most commonly used by psychologists in schools and clinics generally provide an overall score or estimate of "ability" to learn what is typically taught in school. These tests often include a combination of "verbal" (language-based) tasks such as vocabulary and general fund of information and "performance" (nonverbal) tasks such as puzzles and copying patterns. Intelligence tests have become controversial because ethnic and linguistic minority individuals tend to score lower than individuals from white middle class backgrounds and are not usually well-represented in the norming populations used by test publishers. Results should therefore be interpreted cautiously. Commonly used tests include the Wechsler Intelligence Scale for Children (Third Edition), Kaufman Assessment Battery for Children, Stanford-Binet (Fourth Edition) and Woodcock-Johnson Psycho-educational Battery.
- **Achievement tests:** These tests, both norm-referenced and criterion-referenced, measure basic academic skills and content area information acquired through schooling. Psychological evaluations will likely consider specific basic skills needed to master reading, math and written language tasks in order to help identify where instruction needs to be provided or modified. Commonly used achievement tests include the Woodcock-Johnson Psycho-educational Battery: Tests of Achievement, Kaufman Tests of Educational Achievement, Key Math and Peabody Individual Achievement Test.
- **Behavior inventories:** These are usually checklists or rating scales completed either by the child about his or her own feelings and behavior, or by a familiar adult (parent or teacher) who has observed the child's behavior in different situations. Some rating scales are norm-referenced and standardized, while others are criterion-referenced and identify "critical" concerns or serve as screening tools to determine the need for further testing. These tools can show how a child's behavior is perceived in different settings by different individuals, or how a child perceives his or her own behavior compared to the perceptions of others. These procedures can provide very valuable information, but they have some drawbacks: The results are only accurate if the child or adult is able to honestly respond to the questions asked; it can be confusing if different individuals rate behaviors of the same child quite differently. Commonly used examples include the Behavior Assessment System for Children and the Child Behavior Checklists.
- **Personality tests:** Tests which measure personality traits and emotional adjustment include both straight- forward questionnaires and more subjective "projective" procedures. *Diagnostic interviews* and *questionnaires* involve directly asking children about their feelings in specific situations, about their fears and concerns, etc. *Projective tests* include a variety of procedures which *indirectly* evaluate feelings and personality characteristics by providing the child with vague or ambiguous situations, pictures, stories, etc. and considering the responses as indicators of underlying personality traits, fears, anxieties and life stressors. Drawings by the child can also be used in this manner. Interpretation of projective tests is far more subjective than interpretation of direct questions and behavior inventories. Some commonly used personality tests include the Minnesota Multiphasic Inventory-Adolescent Form (MMPI-A) and projectives such as the Rorschach (inkblots) and Thematic Apperception Test (TAT).

Additional Resource for Parents

National Association of School Psychologists (Martin, M. & Waltman-Greenwood, C., Eds.) (1995). *Solve your child's school-related problems.* New York: HarperPerenniel.

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Reading: Developing Positive Attitudes in Children

A Handout for Parents

by Joann Mullen, Ph.D., NCSP
Trumbull County (OH) Board of Education

Overview

In the classroom, reading instruction typically focuses on specific *skills* such as sounding out words and building vocabulary. However, the development of positive reading *attitudes* is often overlooked. Children with positive reading attitudes tend to be willing to read, enjoy reading, and become lifelong readers. On the other hand, children with poor attitudes toward reading may only read when they have to read, tend to avoid reading, and may even refuse to read altogether. A child's attitude toward reading may have a profound impact upon his or her overall academic progress.

Background

As children progress from early childhood through their school years, they develop strong likes and dislikes, including positive or negative attitudes toward reading. Parents may underestimate the critical role they play in the development and shaping of their child's reading attitude. For example, young children view their parents as experts. Therefore, the information and values that parents share with their children about the importance of reading can significantly affect the attitudes that children develop. Parents are also role models for their children. By observing the attitudes that their parents exhibit — both verbally and nonverbally — toward reading, children will tend to develop and demonstrate similar attitudes. Furthermore, because children (particularly preschoolers) seek and desire approval from their parents, they tend to develop the attitudes and values that parents will praise and reinforce.

What Can I Do as a Parent?

- Provide a variety of reading materials, such as magazines, newspapers, books, dictionaries, encyclopedias and other reference materials in the home. These can often be purchased at used bookstores or library sales. By having easy access to reading materials, your child will be more likely to read for pleasure and/or to obtain information.
- Let your child know how much you enjoy and learn from reading a book, newspaper article, magazine story, etc. As a result, your excitement and interest in reading will transfer to your child. Just observing *you* read helps your child to become aware of the value you place on reading.
- Read with and to your child. Young children as well as older children enjoy listening to stories read with and to them. Also consider setting aside a "family reading time" on a regular basis. Each member of the family could read a portion of a book.
- Visit the library so that your children can select their own reading materials based on their individual interests. Frequently, "story time" is offered at the local library, which can be a particularly enjoyable activity for young children.
- Acknowledge your child when he or she reads or shares information obtained from reading. Because children want to please their parents, your recognition and positive reaction will have a significant impact upon their desire to read.

Be aware of the many activities of modern society which compete for reading time — video games, television, sports, computers, etc. Parents today face a significant challenge to create a home environment that supports and instills a love for reading. However, your efforts will bring your children the gift of a life-long habit of reading!

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Retention and Promotion

A Handout for Parents

Andrea Canter, Ph.D., NCSP, Minneapolis Schools
Karen Carey, Ph.D., California State University/Fresno

Background

Every year, many children are held back in the same grade. Teachers and administrators might recommend retention (or nonpromotion) when children have difficulty keeping up with their classmates in academic subjects or fail to master grade-level "standards" in district or state-wide testing. Retention might be recommended because children are smaller than classmates, appear "immature" or have later birthdays and seem to need a chance to grow. And, retention is sometimes recommended to help children who have missed a lot of school due to illness or frequent moves, or who are just beginning to learn English. Although in some school districts, retention is used frequently, especially with kindergarten and first grade children, the practice is very controversial among educators and researchers. Some note that research does not support the notion that retention helps children to "catch up", while others note that "social promotion"— sending children on to the next grade regardless of performance — merely pushes children through the school system without requiring mastery of basic skills.

What Does the Research Say?

Retention has been studied for many years, and the results of most studies consistently show that:

- Most children do not "catch up" when they are held back. Although some retained children do better at first, they often fall behind again in later grades, and are often referred for remedial help or special education during elementary school.
- Some children seem to suffer no ill-effects from retention. However, by the time they enter middle school, many children who were held back tend to get into trouble, dislike school, and feel badly about themselves more often than do children who were never retained. There is some evidence that retained children are more likely to have mental health problems than those who are not retained.
- "Transition kindergarten" is a type of retention and generally is no more helpful than promotion to first grade.
- The most consistent finding is that retained children have a much higher likelihood of dropping out of school than nonretained children.
- Retention might be less harmful for children who feel good about themselves, get along well with others, and have the skills to catch up easily. It is often difficult to predict which children will benefit from retention, however.
- Retention might be helpful for a child who missed a lot of school due to illness or family moves, if the attendance problem is solved and the child will be only one year older than classmates.
- Simply promoting a low performing child on to the next grade is not an effective practice.

What Can Parents Do To Help?

Neither retention nor promotion will help a child learn! But in order to succeed, your child might need different instruction, not the same things again that didn't work the first time. Parents and teachers can work together to help children succeed. By catching the problem early, there are more opportunities to help children before they have a sense of failure, and there are greater chances for success.

Discuss concerns with your child's teacher. Find out what work your child is expected to do, and what work your child finds difficult. Ask a lot of questions—how does he or she get along with classmates? Does he or she understand and remember to follow directions? Does he or she finish assignments on time? What changes has the teacher tried to help your child? Are there other ways to teach the same material? Are there other books and materials that might help your child learn? What are some activities that you can help with at home to help your child catch up? Ask the teacher for some ideas! And try to find a time to visit the classroom and watch your child at work.

Help your child with schoolwork at home. Ask your child about homework each day. Help him or he to find a quiet time and place to study. Check to see if your child can explain the assignment to you or read the directions. Make sure your child understands that you think schoolwork is important.

Make sure your child is ready for school each day! Be sure your child attends school on time every day, eats balanced meals, gets enough sleep and receives good medical care. Children need to be alert and healthy to succeed in school!

Where Can I Get More Help?

It can be frustrating to know your child is not succeeding at school. It can make a parent feel upset or angry. Before considering retention, parents can get help from other professionals at school. These people offer ideas for parents and teachers about how to change instruction. They also provide testing to find out if a child needs other services such as tutoring or special education and may have some different learning materials that will work with your child. They can help children who have low self-esteem or poor social skills so that they "fit in" and feel better about themselves. At your child's school, you might contact the:

- School psychologist
- School problem-solving or support team ("Intervention Assistance Team")
- School social worker
- School nurse
- Guidance counselor
- Special education teacher
- Reading specialist
- Principal

For more Information, contact your school psychologist or:

The National Association of School Psychologists, 4340 East West Highway #402, Bethesda, MD 20814; Website at <*http//:www.naspweb.org*>

Resources

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Original handout published by NASP (1992); revised by Andrea Canter, Ph.D.,NCSP (1998)

National
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Psychologists

Retention and Promotion

A Handout for Teachers

by Andrea Canter, Ph.D., NCSP, Minneapolis Schools
and Karen Carey, Ph.D., California State University-Fresno
and Peg Dawson, Ed.D., NCSP, Center for Learning and Attention Disorders, Portsmouth NH

Background

Every year over 2 million American school children are retained in the same grade. By ninth grade, approximately 50% of all students will have been held back at least once. Teachers and administrators might recommend retention (or nonpromotion) when children have difficulty keeping up with their classmates in academic subjects or fail to master grade-level "standards" in district or state-wide testing. Retention might be recommended because children are smaller than classmates, appear "immature" or have later birthdays and seem to need a chance to grow. And, retention is sometimes recommended to help children who have missed a lot of school due to illness or frequent moves, or who are just beginning to learn English.

Although in some school districts, retention is used frequently, especially with kindergarten and first grade children, the practice is very controversial among educators and researchers. Some note that research does not support the notion that retention helps children to "catch up", while others note that "social promotion"—sending children on to the next grade regardless of performance—merely pushes children through the school system without requiring mastery of basic skills.

A survey of the research literature shows that student retention, for the most part, is of questionable educational benefit an may have negative effects on achievement, self-concept, attitudes toward learning, and school drop-out rates. The practice of retention costs American taxpayers more than \$9 billion dollars each year! Furthermore, retention appears to be a discriminatory practice as boys, Blacks and Hispanics are far more likely to be retained than are other students.

Research

Commonly held beliefs about the benefits of retention have been dispelled by decades of research:

Low achievers rarely "catch up." Most children do not "catch up" when they are retained, and in fact are more likely to fall further behind. Some children show initial gains following retention but long-term studies show that these gains "wash out" within two or three years. Promoted peers with similar skills fare at least as well academically, and often do better.

Retention is generally unsuccessful even at kindergarten or first grade. While some research suggests that retention has more negative effects for older students, even retention of kindergarten children appears to be an ineffective intervention. Research indicates that students are more likely to be hurt by retention than helped, regardless of grade level. "Transition kindergarten" is a type of retention and generally has not been proven to be effective. Furthermore, research suggests that early retainees are most likely to be identified for special education or other remedial services later, making it critical that failing young children are thoroughly evaluated to determine need for specialized instruction rather than merely retained.

"Immature" children do not benefit from an extra year to grow. There simply is no evidence that children will mature faster or adjust better when retained. Students do not benefit emotionally from retention, and many retained students experience more mental health problems later in middle school and high school.

Retained students are more likely to drop out of school. The drop-out rate among retained students is much greater than for similarly achieving students who have never been retained. The probability of dropping out increases with multiple retentions. Even for single retentions, the most consistent finding from decades of retention research is the high correlation between retention and dropping out.

Social promotion by itself is also an ineffective practice. Merely pushing a failing student through the school curriculum has no impact on achievement. Failing students need changes in their instruction!

Does Anyone Benefit From Retention?

Under some circumstances, retention is less likely to yield negative effects:

- Students who have positive self concepts, good peer relationships, and have adequate skills to catch up easily are less likely to have negative retention experiences.
- Students who missed a lot of school due to illness or family moves might be helped by retention. However, this assumes that the attendance/health problems have been resolved and that the student is no more than one year older than classmates.
- There will always be individual students who appear to have positive experiences with retention. Unfortunately, educators are unable to consistently predict which students will be successful.

How Can Teachers Help?

Since research fails to support retention, it is imperative that schools implement more effective strategies that enable at-risk students to succeed in the regular classroom.

Effective teaching strategies will enhance student success. Mastery learning, direct instruction, adaptive education, team teaching, peer tutoring, cooperative clearing and curriculum-based assessment have all been shown to produce academic gains in students at all achievement levels. If the child works slowly, cut down the number or length of assignments. Look for ways to modify the curriculum. Reward students for their efforts! Teachers may need inservice training and consultation to help implement new methods in the classroom.

Catch the problem early. If a child has difficulty keeping up with classmates, look for ways to help before the problem becomes serious. Observe the child while he/she works on assignments to determine the skills the child is missing. This can lead to a minimal amount of reteaching.

Establish activities that encourage parents to become involved in school. Teachers can offer parents opportunities to observe instruction, to learn about class assignments, and expectations for success. Support staff can work with parents to increase their skills as "teachers" and as advocates for their children's learning. An atmosphere that welcomes parents as partners will promote better communication between home and school, and in turn will promote learning and appropriate behavior.

Seek assistance from the members of the school multi-disciplinary team. Teachers can't be expected to solve all classroom difficulties alone! Members of the school team (psychologist, social worker, counselor, principal, nurse, Chapter 1, etc.) have training and expertise to support efforts in the classroom and to help involve parents and appropriate community resources. It's important that students receive supportive services before they are entrenched in a cycle of failure.

For more information about retention, contact: The National Association of School Psychologists, 4340 East West Highway #402, Bethesda, MD 20814.

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School Choice

A Handout for Parents

**by Camilla Lehr, Center for Educational Outcomes
University of Minnesota**

School Choice: What Is It?

School choice is quickly becoming one of most popular school reform strategies of the 1990's. This reform policy offers the opportunity for parents to choose the school they would like their child to attend, in contrast to traditional policies that assign the child to a school based on predetermined parameters. Although school choice plans offer the option of choosing a school, school choice does not guarantee that a student will attend the school that has been selected. Attendance may be denied if enrollment at a particular school is filled or if the racial balance of the school (as dictated by state level desegregation laws) is upset.

Many different forms of school choice exist nationwide, and the extent of choice that can be exercised varies widely across school choice plans. For example, some plans partially restrict the educational choices parents and students can make ("controlled-choice"), while others have virtually no restrictions ("open enrollment"). In addition, schools of choice include a wide variety of organizational structures, ranging from magnet and charter schools to postsecondary options. The critical feature is that the school of attendance is selected by the student and/or parent(s).

History of Public School Choice

The school choice movement arose as a result of concerns about the status of the country's educational system and providing equal access to quality schools for all students. Ideally, it is hoped that public school choice can be used as a vehicle to provide equal access to all families by allowing parents to choose the school they think is best for their child. During the 1960's and 1970's, school choice options most often took the form of alternative schools and magnet schools. These schools were created in response to the need for different forms of schooling for students who were not doing well in traditional public schools or who desired a nontraditional program. Public school choice as a major factor in nationwide school reform was introduced in 1986.

The concept gained popularity and was endorsed by the National Governors' Association and supported by President Bush's administration in 1988. Currently, there are at least 33 states that have passed or are proposing some form of school choice legislation.

Why Do Parents Choose to Transfer Their Children?

Many of the school choice programs in existence today emphasize parental involvement in choosing a school for their child. Support for the idea of parental choice is apparent in the results of a Gallup poll (1991) which indicated that 62% of parents wanted the opportunity to choose a school for their child. In 1993, almost one-fifth of children attended schools other than their assigned public school. A National Household Education Survey conducted in 1993 revealed three reasons why parents choose public schools for their children:

- better academic environment (26%)
- special academic courses (23%)
- school convenience (23%).

It should be noted that many of those who are choosing to transfer are parents of children with disabilities and special needs. For example, in Minnesota (the first state to initiate comprehensive school choice legislation), results from surveys indicated 10% to 19% of the students accessing various choice options are students with disabilities. The top four reasons from a statewide survey asking why parents of students with disabilities decide to transfer their children included:

- my child's special education needs are better met at the chosen school (64%)
- teachers at the chosen school can give may child more personal attention (41%)
- we were unhappy with our former school district (40%)
- special education teachers at the chosen school keep me more informed of my child's progress (38%).

Arguments For and Against School Choice

Advocates believe that school choice will help:

- improve school quality by fostering competitiveness between school programs;
- move more decision making to the school level, which will increase staff and parents' sense of membership, involvement and commitment to the school;
- professionalize teaching and enhance teacher performance by providing opportunity to create distinctive programs and develop the curriculum;
- increase student attendance, effort, and provide more opportunities for students to experience success.

Those who argue against school choice believe that :

- parents may not choose wisely, and reasons for choosing a different school will be based on issues such as distance or the best athletic program;
- information about the right to choose will only reach a select group of parents, and those who could benefit most may not be adequately informed;
- there is very little to no hard evidence to support the notion that any of the beliefs held by advocates have been met;
- these options may further segregate rather than desegregate groups of students.

What Are the Various Choice Options?

The availability of various school choice plans varies widely across states. In addition, forms of school choice vary widely in their underlying assumptions and operational procedures. However, all school choice options encourage or require students and their families to become actively involved in the decision to choose another school.

Although the variety of school choice plans makes summarization difficult, a few major types have been identified. Again, it is important to remember that some choice plans partially restrict the educational choices families can make while others have very few or no restrictions. Most choice plans fall near the middle of the continuum between the two types. Listed below are some choice options and their definitions.

Intradistrict choice. A plan that allows students to choose schools within one public school district (may include choice of a few to all schools in the district). This option is common, and it is probably the option that is most familiar.

Interdistrict choice. A plan in which students may cross district lines to attend school. Unlimited interdistrict choice is equivalent to statewide open enrollment.

Controlled choice. A student assignment plan that requires families to choose a school within a community, but choices can be restricted to ensure the racial, gender and socioeconomic balance of each school.

Magnet schools. Public schools that offer specialized programs, such as a concentration on performing or visual arts, math and science, foreign language or computers, while fulfilling basic state requirements for graduation. Magnets may also feature a particular approach to learning or a particular learning environment.

Postsecondary options. Programs that enable high school students to enroll in college courses at government expense. Courses they take may contribute to high school graduation requirements as well as to their college programs.

Second chance programs. Alternative schools and programs for students who have difficulties in traditional public school settings or who are at risk of school failure. Programs may target students who are pregnant or parents, assessed as chemically dependent or dropouts.

Charter schools. Publicly sponsored schools that are largely free of state requirements, but are held accountable for achieving certain levels of student performance (and other specified outcomes).

Workplace training. Apprenticeship programs to teach students a skilled trade not offered through present vocational training.

Voucher plans. Any system of certificate or cash payments by the government that enables public school students to attend schools of their choice, public or private. Vouchers have a fixed value and are redeemed at the time of enrollment.

Tuition tax credits. A system of funding choice that allows parents to receive credit against their income tax if their child attends a nonpublic school.

Choosing a School

When considering a decision about transferring a child to a school of choice, parents should ask themselves "What is best for my child?" and "Where can my child's needs be best met?" If your child is already in school, discussion with your child's teacher or another staff member who is knowledgeable about your child may help to give you more information about how your child learns best. Parents should visit several schools or programs they are considering to see whether they meet expectations.

When visiting a school, note whether staff provide written materials, verbal information or an open house to help with your decision. Some considerations in choosing a public school are listed below:

General program characteristics. How many students does the program serve? What is the student to staff ratio? How long has the program been in existence?

Mission. What is the mission of the school? Is there evidence that the mission is being implemented?

Curriculum and programming. Is there a curriculum in place? Are there goals and objectives for students? Are expectations set at an appropriate level? Is the work engaging and challenging? Are accommodations and adaptations made to meet students' needs?

Classroom structure and teaching approach. Are the classes organized, flexible, closely supervised, structured, competitive or cooperative? Does the classroom structure match my child's needs?

Quality of staff. Are teaching staff licensed? Do they appear to possess good management skills, organizational skills and knowledge of instructional skills? Are they accountable for student learning?

Availability of special programs. Are services and staff available for students with special needs (e.g. special education, bilingual instruction, enrichment)? How are services delivered? Does the school provide education in the areas of art, physical education, or music? Are after school or extracurricular activities available? Is technology available and are computers being used in the teaching learning process?

Evaluation procedures. How is student progress measured (e.g. standardized tests, portfolios, grades, authentic assessment)? Is an overall program evaluation procedure in place? Is documentation of student progress on a school wide basis available? Does the school regularly survey students or parents about their level of satisfaction? Does the school follow-up on any of their graduates?

School climate and atmosphere. Is the school warm and inviting? Do displays reflect a caring environment? Do teachers greet students by name?

Sensitivity to diversity. Are individual differences in children and staff celebrated? Is there a sense of respect that is apparent between staff, students and parents?

Communication. In what form and how often is student progress or concerns communicated to parents? Are conferences held regularly and at convenient times?

Parental involvement. Is parent involvement encouraged? Are parents included in decision making? Are parents members of an advisory or governing board?

Practical considerations. Is transportation provided? How will this move affect friendships? Is a lunch program provided? Is the school located in a safe place? Is the building clean and well maintained?

Although school choice provides the opportunity for parents to select the school they want their child to attend, it does not ensure that the chosen school is of better quality than the school previously attended. As Peter Cookson, who has done extensive research on school choice, points out, "School choice without good schools is meaningless."

How Can I Find Out More About School Choice and Available Options?

School choice is a dynamic reform policy and plans are frequently being modified or proposed. In order to keep up with the latest information and to find out more about school choice it may be helpful use the following resources:

- Parents of students who are accessing a public school choice option
- Staff members at a school of choice
- Local school district personnel (teachers, principals, assistant superintendents)
- State Department of Education
- Education Commission of the States web site: *http://www.ecs.org* [Search: public school choice, open enrollment]. Telephone: 303-299-3600; FAX: 303-296-8332; E-mail: *<ecs@ecs.org>*

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School Dropout Prevention

Information and Strategies for Parents

by Leslie F. Hale, Ed.D., NCSP
Bartlesville, OK

High School Dropouts Cost Everyone Something!

There are both personal and societal costs of dropping out. The loss of taxes, loss of production and the cost of assistance provided to dropouts make the problem of high school non-completion an issue for every taxpayer. Each year's class of dropouts will cost the country over $200 billion during their lifetimes in lost earnings and unrealized tax revenue. Dropouts comprise nearly half of the heads of households on welfare and an even higher percentage of the prison population. The average annual cost of maintaining a prisoner is at least three times higher than the annual dollars expended to educate a school-age child. This cost does not take into consideration the costs of adjudicating the crimes that sent these dropouts to prison and the monetary and personal costs of the crimes themselves.

The personal costs of dropping out include earning only half as much annual income as a high school graduate by the time prime working age is reached, while the likelihood of living in poverty is nearly three times higher for high school dropouts than for those who finished high school.

How Big is the Problem?

Calculating an accurate dropout rate is nearly impossible, since schools differ in their definitions of a dropout, their counting methods, and their methods of following a student who drops and reenters, or those who leave the district and reenter another one. Even with the discrepancies in data collection methods, it still appears that *no less than 15%* of all persons aged 16 to 24 are not enrolled in school or have not earned a high school diploma or equivalency certificate. The rate of high school non-completers aged 16 to 24 in many urban areas is as high as 35%. The 1994 U.S. Bureau of the Census indicated that 20% of adults over the age of 25 had not completed high school.

Who is At Risk for Dropping Out?

Ethnic status: Demographic information suggests that while African American students complete high school at a lower rate than whites, when adjusted for differences in family socioeconomic status, their completion rate is comparable. Hispanic and Native American students, however, have lower high school graduation rates than whites and blacks, even when socio-economic status is taken into consideration. By the year 2010, the Hispanic population is expected to be the largest minority group in the U.S., or 21% of the population. Dealing with the dropout population in this particular group has become the primary concern in many urban areas.

Gender: It appears that boys and girls do not significantly differ in dropout rates. However, they seem to drop out for different reasons: Girls are most likely to drop out of school due to pregnancy and marriage, while boys are more likely to drop out to seek employment. Additionally, boys are twice as likely to dropout as girls due to behavioral difficulties.

Achievement: Poor academic performance is the single strongest predictor of dropping out of school. Poor grades and low test scores, regardless of ability, may increase student frustration and reduce motivation to stay in school. Additionally, retention in grade is highly related to dropping out of school — some research indicates that retained students are three times more likely to dropout than nonretained students.

Behavior: Students who drop out are more likely to have a history of serious behavior problems than those who complete high school, and this history may date back to the primary grades. Prevention efforts may be enhanced by viewing behavior problems as symptoms of disengagement from school that can be addressed if identified early.

School attendance: School dropouts have higher rates of chronic truancy and tardiness that those who stay in school. Attendance problems can be an early signal that the student is disengaging from the schooling process; daily school attendance reflects both student motivation and parental support.

Student attitudes toward school: Students who drop out are more likely to perceive the school setting as nonsupportive and/or irrelevant. Some researchers suggest that the student's psychological attachment to school and investment in learning are keys to academic and social success, and consequently keys to remaining in school.

Family characteristics: Limited economic resources is highly related to school dropout rates, but the relationship appears to be indirect. Many at risk factors are related to family income— parents' education, single parenting, academic achievement, behavior problems and school attendance. Parent attitudes are clearly related to student engagement in learning and graduation rates: Parents of dropouts are more likely to view school negatively, to have minimal involvement with school and to place little value on school attendance and achievement. Siblings as well as parents are likely to influence a student's decision to drop out of school— students who have a sibling who dropped out of school are at much higher risk of dropping out themselves. Families from diverse cultures and families whose primary language is not English also face additional barriers to school engagement that appear to place students at-risk for dropping out. School personnel may misunderstand customs and parenting styles as lack of interest in schooling, and fail to identify appropriate and effective means of promoting parent involvement in education. These students are more likely to experience alienation and to disengage from the school setting.

Peer relationships: Dropouts are more likely than nondropouts to report social isolation and lack of involvement in school-based social activities. While dropouts tend to be involved in community-based activities, those who remain in school identify with cl

What Can a Parent Do to Keep a Student in School?

An unsuccessful, and often unhappy, student affects the whole family. When a student drops out of school it is easy to blame the student for his or her school failures. Sometimes the student has neglected attendance and school work. Sometimes the school has not been responsive to the individual needs of the student. Sometimes school staff feel that the parents should have been more responsive to the school's efforts to help.

While assigning blame for the unsuccessful student may feel good to the blamer, it doesn't address the most important problem: What can be done to educate this student? Following are some hints to get you on the road to problem solving:

Focus on student goals: Instead of focusing on why the student is unsuccessful in school, have the student identify what he wants to get from the school experience. Have him/her list school, home, and personal barriers to reaching that goal. Sometimes talking about getting past the barriers to reaching a goal helps focus efforts more productively than just complaining or quitting.

Encourage school involvement: Encourage your student to attend school regularly and to be involved in at least one extra-curricular activity at school or with groups of students who are currently in school. These activities make the student feel part of the group, important to the school and more motivated to perform in order to participate. If students' lack of academic success restricts them from every activity except academics, they often see no value in continuing to try. They must have something positive to look forward to that will meet the kinship/companionship needs of being a teenager. If they aren't able to meet these needs in the school setting, they often find ways to meet these needs in less desirable settings and groups.

Consider alternative school settings: Speak with the school counselor and/or school psychologist to see if the student's goals can be reached in the current school environment. If not, have the school identify ideas for alternative settings for the student's learning. Include the student in all discussions with school personnel. If you investigate alternative education settings, have the student make the contacts, visits, complete forms and ask questions. He/she must see that personal responsibility is a must when being asked to be treated as an adult.

Consider realistic post-secondary goals: Don't get hung up on the issue of the student going to college. The more important question is "What does the student find interesting?", "What is the student good at?", and "Which of these skill areas is marketable?" If attending college is the way to reach the vocational goal, set steps in place to get there. In many cases, a post-secondary technical training or 2-year community college program is more appropriate to meet the student's goals and get him/her employable. Some facts to remember when helping your student plan his/her educational future:

- Skilled jobs will increase to 65% of all jobs by the year 2000.
- The largest and fastest growing segment of the emerging technical workforce is occupations that do **not** require a 4-year college degree.
- Nearly 30% of college starters leave after the first year.
- The success rate for college completion is 25%.
- Only 25% of all new jobs in the future will require a 4-year college degree.

Consider the GED (general education development) if an appropriate educational environment is not available for your student in the regular school setting. This equivalency examination is very well respected among employers and higher education institutions. Students can study for this examination through community education programs, alternative education programs, or independently. The point is to stress to all students that the diploma or GED is only the **first** step to finishing their education. The workforce of tomorrow will require post-secondary education for even entry level jobs.

Identify special needs: Consult with school personnel to determine if the student might have a specific learning or behavior problem interfering with learning. Low achievement, retention in grade and behavioral difficulties are highly predictive of dropping out of school. Assessment of possible learning and behavior problems might help identify special services to help your student find school more successful.

Resources

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National Dropout Prevention Center at Clemson University, 205 Martin Street, Clemson, SC 29634-5111; (803)656-2599; <*http://www.dropoutprevention.org*>

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School Dropout Prevention

Information and Strategies for Educators

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School attendance: School dropouts have higher rates of chronic truancy and tardiness than those who stay in school. Attendance problems can be an early signal that the student is disengaging from the schooling process; daily school attendance reflects both student motivation and parental support.

Student attitudes toward school: Students who drop out are more likely to perceive the school setting as nonsupportive and/or irrelevant. Some researchers suggest that the students' psychological attachment to school and investment in learning are keys to academic and social success, and consequently keys to remaining in school.

Family characteristics: Limited economic resources is highly related to school dropout rates, but the relationship appears to be indirect. Many at-risk factors are related to family income— parents' education, single parenting, academic achievement, behavior problems and school attendance. Parent attitudes are clearly related to student engagement in learning and graduation rates: Parents of dropouts are more likely to view school negatively, to have minimal involvement with school and to place little value on school attendance and achievement. Siblings as well as parents are likely to influence a student's decision to drop out of school— students who have a sibling who dropped out of school are at much higher risk of dropping out themselves. Families from diverse cultures and families whose primary language is not English also face additional barriers to school engagement that appear to place students at-risk for dropping out. School personnel may misunderstand customs and parenting styles as lack of interest in schooling, and fail to identify appropriate and effective means of promoting parent involvement in education. These students are more likely to experience alienation and to disengage from the school setting.

Peer relationships: Dropouts are more likely than nondropouts to report social isolation and lack of involvement in school-based social activities. While dropouts tend to be involved in community-based activities, those who remain in school build social networks connected to school activities and develop a sense of "belonging" to the school that seems critical to continued engagement.

School organization and practices: The school itself appears related to dropout rates. Schools with rigid retention policies, widespread administrative transfers, emphasis on competency testing, tracking and perceived "unfair" discipline practices tend to have higher dropout rates. Large class size, high teacher turnover, low teacher expectations for student performance, and perceived lack of support for students with academic and behavior problems are also related to student decisions to dropout.

Community values: The student's community can also contribute to the desire to remain in school or drop out. Employment opportunities for unskilled workers might encourage dropouts, while communities that clearly value education and encourage school-community partnerships are more likely to establish programs and foster attitudes that maintain student engagement in schooling. Supports available to ethnic minority and low income students are critical to ensure school completion.

Prevention and Intervention Strategies

High drop out rates can impact school and community climate; the consequences for the individual student can be enormous as dropping out has life-long impact. When a student drops out of school it is easy to blame the student for his or her school failures. Sometimes the student has neglected attendance and school work. Sometimes the school has not been responsive to the individual needs of the student. Sometimes school staff feel that the parents should have been more responsive to the school's efforts to help. While assigning blame for the unsuccessful student may feel good to the blamer, it doesn't address the most important problem: What strategies will help keep students in school or encourage students to return to school?

Prevention strategies: Schools can collect data about student performance and characteristics related to dropping out in order to identify potential problems early in the student's school experience and thus refer students for specific prevention efforts. Tracking student attendance, test scores, grades, behavior referrals, participation in activities, school attitudes and family participation in school events can provide information to identify students most at risk for later dropping out.

Prevention activities might include incentives and supports to improve attendance; programs to encourage parent involvement; early intervention for academic difficulties (such as peer tutoring programs); community and school-based mentorships; and partnerships with community business to connect school to work. Development of high school alternative programs that provide nontraditional approaches to vocational training and high school completion will also provide options for students who have not been successful in meeting the academic or social demands of the typical school program.

Dropout retrieval and re-entry programs: Once students have dropped out, it is still possible to re- engage them in the school process through programs specifically designed to help them transition back to a school environment. Recent dropouts need information about alternative routes to attaining a diploma. They need access to support personnel who can help them design a program to meet their individual needs— often this will include individualizing the academic program to address areas of difficulty as well as areas of strength. Some students will also need flexible school hours to fit in needed work opportunities, in-school child care, low teacher-student ratios to ensure more individual support, individual and group counseling and mentoring.

What Can Teachers Do to Help Students Stay in School?

In addition to schoolwide strategies and programs, individual teachers and support staff can help encourage school involvement for students at risk for dropping out:

Focus on student goals: Instead of focusing on why the student is unsuccessful in school, have the student identify what he wants to get from the school experience. Have him/her list school, home and personal barriers to reaching that goal. Sometimes talking about getting past the barriers to reaching a goal helps focus efforts more productively than just complaining or quitting.

Encourage school involvement: Encourage the student to attend school regularly and to be involved in at least one extra-curricular activity at school or with groups of students who are currently in school. These activities make the student feel part of the group, important to the school and more motivated to perform in order to participate. If students' lack of academic success restricts them from every activity except academics, they often see no value in continuing to try. They must have something positive to look forward to that will meet the kinship/companionship needs of being a teenager. If they aren't able to meet these needs in the school setting, they often find ways to meet these needs in less desirable settings and groups.

Consider alternative school settings: Speak with the parent, school counselor and/or school psychologist to see if the student's goals can be reached in the current school environment. If not, discuss options for alternative settings. Include the student in all discussions with school personnel. If parents decide to investigate alternative education settings, encourage the student to make the contacts, visits, complete forms and ask questions. He/she must see that personal responsibility is a must when being asked to be treated as an adult.

Consider realistic post-secondary goals: Not every student is appropriately college-bound. Help the student to identify strengths and areas of interest, and to explore career options that maximize interests and skills. If attending college is the way to reach the student's vocational goal, help set steps in place to get there. In many cases, a post-secondary technical training or 2-year community college program is more appropriate to meet the student's goals and get him/her employable. Some facts to remember when helping students plan their educational future:

- Skilled jobs will increase to 65% of all jobs by the year 2000.
- The largest and fastest growing segment of the emerging technical workforce is occupations that do **not** require a 4-year college degree.
- Nearly 30% of college starters leave after the first year.
- The success rate for college completion is 25%.
- Only 25% of all new jobs in the future will require a 4-year college degree

Encourage exploration of the GED (General Education Development) equivalency diploma if an appropriate educational environment is not available for the student in the regular school setting. This equivalency examination is very well respected among employers and higher education institutions. Students can study for this examination through community education programs, alternative education programs, or independently. The point is to stress to all students that the diploma or GED is only the **first** step to finishing their education. The workforce of tomorrow will require post-secondary education for even entry level jobs.

Identify special needs: Consult with parents and other school personnel to determine if the student might have a specific learning or behavior problem interfering with learning. Low achievement, retention in grade and behavioral difficulties are highly predictive of dropping out of school. Assessment of possible learning and behavior problems might help identify special services to help the student find school more successful.

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Some of the material for this handout is adapted from Kortering, Hess & Braziel (1997), referenced above.

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School Entry Decisions

A Guide for Parents

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How Do We Know if a Child is Ready For Kindergarten?

Are there benefits to delaying kindergarten entrance?
Are there benefits to starting kindergarten early?

Kindergarten readiness is the concept that children have developed a group of skills necessary to learn. It can include readiness to read, write and count; to sit and listen; to follow two-step directions; to ask an adult for help; to interact appropriately with other children; to toilet independently. These and numerous other factors related to readiness are found in popular and child development literature, but there is no universal set of behaviors required for a child to enter kindergarten. In fact, the sole requirement for kindergarten entrance in the United States is chronological age; children must be five years old by a certain date, usually by September first.

What we know about readiness in young children: Young children learn at different rates and markedly so from preschool through age eight. For example, while most children can learn to decode words during their sixth year, it is normal for children to learn as young as four and as old as seven years of age. This wide but normal range is also true for drawing, writing letters and numbers, counting, speaking clearly and following multiple directions. So it is to be expected that a typical kindergarten class should include children entering with wide variation in their school- related skills.

Factors in Delaying Kindergarten Entrance

Although readiness is legally defined as reaching the age of five by a certain date, many parents and educators have become concerned that some kindergarten-age children seem socially or physically immature or lacking the skills to read, write and compute. Over the last 20 years or so, delaying entrance to kindergarten by one year has become a common response, especially for boys who turn five within four or five months of the kindergarten cutoff date. A review of the research on delayed entrance and on children who are the youngest within their grade has shown that:

- Delaying kindergarten until age six has not resulted in improvement in reading, writing or math skills;
- At kindergarten and first grade, youngest children do score lower on achievement tests, but the difference tends to diminish as grade level increases, usually disappearing by third grade (one researcher noted that six-year-olds *should* look more skilled than five-year-olds in kindergarten; they have been alive 20 percent longer);
- Delayed entrants 4 to 12 years after entering school were no more academically skilled, athletically involved or socially successful than students who had entered kindergarten after just turning five years old;
- Students who are one year too old for a grade level are much more likely to drop out of high school.

Factors in Starting Kindergarten Early

While some parents choose to delay their child's kindergarten entrance by one year, there are others who request that their child enter kindergarten one year early, at four years of age. With birthdates one to three months after the kindergarten cutoff, these children tend to be early and quick learners, socially mature and most often girls. Schools that allow early entrance usually require some formal testing and possibly a simulated or "trial" kindergarten experience to determine if the candidates are advanced beyond the typical kindergarten skills. Research on early entrance to kindergarten has shown that when the early entrants, boys or girls, have *superior intelligence*, and when their parents and the receiving teacher *support the decision* and have *realistic expectations* of the child:

- Academic achievement, athletic involvement and social adjustment were at least as great as children of similar intelligence who entered at age five.
- One researcher who reviewed several studies noted that, "there is no reason to conclude that the early entrants would have achieved more and adjusted better if they had entered school at the usual time."

Recommendations for Parents Considering Delayed Entrance

All parents and educators want children to be successful in school. When parents believe their child may struggle or fail in kindergarten, delaying entrance by one year has become a common practice and some educators have recommended it. However, experts in child development generally agree that, rather than trying to fit the child to the program, schools should tailor the program to accommodate the individual differences in the kindergarten class. Teachers should assess each child's entrance skills and design curriculum to advance him or her to the next skill level. So before deciding to delay a child's entrance to kindergarten by one year, parents should consider:

- Meeting with the prospective kindergarten teacher to discuss how the school program would meet their child's individual needs and skill level, keeping in mind that the only school entrance requirement is to be five years old; and/or
- Requesting formal educational assessment if there is concern that the child may have an educational disability. Preschool special education services may be available.

Recommendations for Parents Considering Early Entrance

When parents believe their child is advanced intellectually and socially, early entrance may be one option. Before deciding to request early entrance, parents should consider:

- Meeting with the prospective kindergarten teacher to discuss how the school program would meet their child's individual needs and advanced skill level if the child entered at the regularly scheduled time.
- Exploring enrichment options available in the community during the year prior to regular entrance to kindergarten.

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Section 504

An Introduction for Parents

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Background

Section 504 is part of the Rehabilitation Act of 1973, and applies to all institutions receiving federal financial assistance, such as public schools. The law essentially places an obligation on public schools to provide a "free appropriate public education" to children with disabilities, along with related services such as transportation and counseling. The main purpose of 504 is to prohibit discrimination while assuring that disabled students have educational opportunities and benefits equal to those provided to non-disabled students. Although Section 504 took effect in 1973, many states have not developed policies or guidelines on 504. Section 504 is anti-discrimination legislation, not a federal grant program. The Office of Civil Rights (OCR) monitors compliance under 504. Unlike special education laws, Section 504 does not provide financial support to schools.

A student is considered to be handicapped under 504 if he or she (1) has a physical or mental impairment that substantially limits one or more major life activities, or (2) has a record of such an impairment, or (3) is regarded as having such an impairment. Limiting a major life activity is an important part of this definition and includes handicaps that limit taking care of oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing or learning. The last example, learning, is the one frequently considered in 504 cases in the schools. Section 504 requires school districts to offer services to some children who might not qualify for special education benefits under the Individuals with Disabilities Education Act of 1990 (IDEA; this federal act funds special education services). For example, children who have AIDS, asthma and diabetes may all be covered under Section 504.

Eligibility/Assessment/Accommodations Under 504

Although schools are not necessarily required to evaluate children based only on a parental request for evaluation, the school must still inform parents of their rights to dispute their decisions. Schools must notify parents of their rights regarding identification, evaluation and placement of children with suspected handicaps prior to starting a Section 504 evaluation. In addition, students who are not found eligible under IDEA should be considered for possible eligibility under Section 504. In a 504 referral, the school often tries to determine: (1) Does the student have a physical or mental impairment? (2) Does the impairment affect one of the major life activities? If the answers to these questions are yes, the student may be entitled to a Section 504 accommodation plan. Accommodations must be based on a child's educational needs and may include curricular, classroom, school and grading modifications.

Section 504 requires school districts to develop detailed procedures for identifying and serving children with disabilities. Under 504, school districts must annually publish public notices stating that they do not discriminate, with the notice specifying the person selected to coordinate the district's efforts to comply with Section 504. Most school districts are required to have a Section 504 coordinator. This coordinator is usually selected from local district personnel, such as superintendents, guidance counselors and special education directors. Like other special education laws, 504 requires schools to conduct activities that will help locate and identify children who have disabilities and are not currently receiving needed special services. A notice of these activities should be sent to parents or put in places where parents of children with disabilities are likely to see them.

Parental Rights and Procedures Under 504

Referral: Parents, guardians or school personnel may refer students suspected of having a handicap to the Section 504 coordinator or similar personnel. Potential candidates for 504 services include children with cancer, communicable diseases, medical conditions and Attention Deficit Hyperactivity Disorder.

Information about rights: Parents and guardians should be provided their rights under Section 504: 1) when eligibility is determined, 2) when a plan is developed and 3) before there is a significant change in placement.

Evaluation procedures: The school's procedures for evaluation must ensure that the tests are appropriate for the child's specific educational need, are administered by qualified personnel and are comprehensive.

Right to a hearing: If the parents or guardians disagree with the identification, evaluation or placement of their child, they have the right to an impartial hearing with school personnel.

Rights of due process: Under 504, parents have the rights of due process. These rights include the right of notification, the right to inspect records, the right to participate in a hearing with representation and the right to a review procedure.

Services under 504: If a child is found eligible under 504, services are primarily provided in the regular education classroom. The types of services offered might include the use of behavioral management techniques (e.g., a token economy), adjusting class schedules, modifying tests and tailoring homework assignments.

Home-school collaboration: Parents can help increase the likelihood that 504 plans are effective by working closely with general educators and other school personnel to implement intervention programs both at school and at home. Regular parent-teacher conferences are likely to help foster this relationship.

Resources for Parents

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Study Skills

A Handout for Parents

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Overview

Many capable children at all grade levels experience frustration and failure in school, not because they lack ability, but because they do not have adequate *study skills.* Good study habits are important for success in school, to foster feelings of competence, to develop positive attitudes, and to help children realize they can control how well they do in school and in life. Good study habits lay the groundwork for successful work habits as an adult.

For children to learn good study skills, teachers and parents must work together. It is most important to help children build good habits, to develop a system that works for an individual child, and to use the system effectively and consistently. Preferred learning styles vary from child to child. Children need to discover how they learn and then work out a study system that fits best. Parents of elementary aged children usually help their children more than parents of adolescents. However, adolescents also need parental support and encouragement throughout high school.

Four Basic Principles to Enhance Study Skills

1. Make homework completion a positive experience: associate it with love and affection, freedom, fun and control.
2. Make homework completion a high priority.
3. Use homework completion to teach organization skills and improve learning skills. Remember that the primary purpose of homework is to improve learning and foster work habits.
4. Provide and enforce logical and meaningful consequences.

Make Homework Completion a Positive Experience

Associate it with love and affection, freedom, fun, and control. Possible ways to do this are to:

- Provide support and praise for homework completion.
- Be available to provide non-critical assistance.
- Give children choice in when, where, and how they complete homework assignments.
- Encourage your children to complete homework well enough that they have a sense of control over their own learning and levels of competence.
- Maintain a positive and helpful attitude: avoid criticism and anger.
- Help children understand what types of homework they enjoy and encourage them to choose assignments accordingly. Some prefer written reports, others prefer hands-on projects.
- Use homework preferences in developing a homework schedule. Some children prefer to get disliked homework done first, while others prefer to do their easier work first.
- When a child dislikes subject, find ways to make it less frustrating. For example, set a goal of doing five math problems and then taking a stretch.
- Encourage your children to participate in study groups with friends. Research shows that children who form study groups achieve at a much higher level than children who always study alone.

- Encourage your child to have fun such as eating a snack, calling friends, starting an activity, or watching a favorite show when homework is finished.
- Never use homework as a punishment.
- Be a good listener, and encourage your child to ask questions about things that are hard to understand.
- Set aside time for your children to share with you the skills and information they are acquiring.
- Help children study for tests by quizzing them on the material in a friendly manner.
- Have your children imagine themselves as excellent students. Then brainstorm what needs to be done to make that a reality.

Make Homework Completion a High Priority

- Make clear that you expect your children to complete homework well.
- Establish a study routine: children should be in the habit of studying at the same time and in the same place each day. Children and parents should decide, together, upon the study routine by taking into account scheduled activities, family commitments, and favorite TV shows. Also, consider the child's ability to concentrate at different times of the day. Many elementary school children are too tired after dinner, and show this by having trouble concentrating, being easily frustrated, and being slow to complete tasks. Ideally, the family agrees upon a study hour, the television and stereo are off, phone calls are not taken, and the entire family studies, reads, or completes paperwork.
- Establish a place to study with good lighting and a table or desk. Some children prefer to study in their own room. Others do better if they are studying at the kitchen table or other location near parental help. Some children are able to study with a little background noise such as music. Few can study effectively in front of the TV and most need uninterrupted quiet. Other children may prefer to work at the library, and will need transportation.
- Have supplies on hand including binders, notebooks, paper, pencils, pens, assignment books, erasers, dictionaries, a calculator, ruler, hole punch, tape, glue, reference books and/or programs.
- Demonstrate, and enforce, that homework completion is a higher priority than other activities. A child should not watch TV and talk with friends before completing homework, unless time later in the day has been set aside upon for homework completion.
- Reduce activities if a child has so many commitments that there is insufficient time for homework.
- Have help available for every subject. This might be a parent, neighbor, friend, teacher hot line, an on-line homework service, or a tutor. The helper needs to be someone who is knowledgeable about the subject and who can help the child without becoming frustrated or angry.
- Establish a family expectation that studying for exams is expected and takes priority over other activities.

Use Homework Completion to Teach Organization Skills and Improve Learning

Keep in mind that the primary purpose of homework is to improve learning and foster work habits Possible ways to do this are to:

- Encourage your child to use an assignment book, write all assignments into the book daily, and check them off when completed. Your child should also break down long term assignments, such as projects, into smaller parts and write each part into the assignment book. Many children also find it helpful to put other commitments into the assignment book as well, including music lessons, sports, and jobs.
- Encourage your children to estimate how long it will take to complete each assignment and plan their schedule accordingly.

- Help your children set goals regarding how well they want to do on an assignment and how much effort it will take to do that well. This will help them learn to divide study time effectively.
- Help your children learn to plan for finishing assignments on time. They should start working on major assignments or reviewing for major tests well ahead.
- Help your children expand their concentration time. At first they may be able to concentrate for only 10 minutes. Parents can help their children build up this length of time gradually, so that homework takes less time. Even high school students should take a 10 to 15 minute break after studying for 45 or 50 minutes. Otherwise, they lose the ability to concentrate.
- Encourage your child to circle the verbs in directions.
- Encourage your child to review class notes and add details, make corrections, and highlight the most important information.
- Encourage your children to improve reading skills by having them pre-read non-fiction reading assignments (reviewing the headings, picture captions, reviewing tables, charts, and graphs). Children can pre-read fiction by reading the front cover, back cover, and introduction, and skimming the first quarter to determine setting, character, and plot.
- Encourage your child to determine the meaning of unknown words by using the context or by looking them up in a dictionary and writing them down.
- Help your child learn effective reading techniques such as SQ3R, where the reader:

  Surveys: Looks over the material before beginning to read to obtain a general orientation.
  ***Q**uestions*: Writes down questions about the material before beginning to read.
  ***R**eads* through the material in the normal way.
  ***R**ecites and Writes*: Writes down or gives the answers to another person.
  ***R**eviews:* Goes over the material several times before being tested.

- Encourage your child to outline or "map" reading material for better understanding. To "map," a child places the main topic in the middle of a blank sheet of paper. Then a branch is drawn for each subheading, and supporting details are placed on smaller branches going out from the subheadings. This creates a visual aid that increases organization and comprehension.
- Make sure your children are able to understand their textbooks. Children should be able to read 9 out of 10 words accurately and answer correctly a least 3 out of 4 questions.
- Help your child predict outcomes, distinguish fact from opinion, discern emotional appeals, recognize bias, discern inference as they read.
- Encourage your children to organize thoughts before beginning a written assignment, and write at least two drafts.
- Have your child proofread and check for success or failure in answering the purpose of the assignment, legibility, neatness, spelling, complete sentences, and punctuation errors.
- Help your child to see tests as an opportunity to "show off" what they have learned, rather than something to be feared.
- Help your children predict test questions as they study for tests.
- Encourage your child to space learning over several sessions instead of cramming the night before. Five hours of study spread over a week is better than studying five hours the night before the test: cramming for tests increases anxiety and causes lower grades.
- Avoid acting as a tutor for your child. If a child needs a tutor in a particular subject, call the local high school and ask for a student tutor through the Honor Society.

Provide and Enforce Logical and Meaningful Consequences

- Each week, have your children assess their own homework completion by reviewing returned papers, tests and quizzes, and current grades. With your children, note their progress, improvements, areas of need, and jointly plan how to solve any problems.

- Display well-done work in a prominent place, such as on the refrigerator door.
- With their help, graph your children's grades. Include the grades for each class, the average grade for all classes, and an agreed upon target line. The target line should be the grades that you and your children agree are reasonable and obtainable (if your child is now receiving D's, a reasonable goal is grades of C: to first set the goal at A's will lead to frustration). Discuss the graph with your children, help your children identify any patterns of poor performance, and jointly develop solution plans.
- Teach your children to bring all necessary materials home. If your children get in the habit of "forgetting" homework materials, have them spend time on reading or working on other academic activities during the agreed upon study time. Your children could also walk back to school to pick up forgotten materials, or be charged "gas money" out of their allowance for being driven back to school. Or, with the help of a school psychologist or counselor, set up a system that rewards them for bringing everything home.
- Sometimes children "lose" completed homework in their books or backpack. Placing all completed homework in one folder in the backpack can solve this problem.
- If a child does not complete homework, reduce the freedom the child has until grades improve and the teacher indicates that the problem is solved. Methods of reducing freedom might be (a) giving your child less control about where and when homework is completed, (b) parents checking the quality of completed homework every evening, (c) parents and teachers maintaining ongoing communication in the assignment book, or (d) the child not being able to participate in a planned activity such as a field trip.
- Reward your child for good grades and for improving grades. Your child's preferences should be considered in deciding upon the reward, but the rewards need not be expensive. Going out together for an ice cream cone, or telephoning a grandparent to tell them of the child's success, are examples of inexpensive but effective rewards.
- Provide support and genuine praise for homework completion and good study habits.

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Understanding Test Scores

A Handout for Parents

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Background: Using Test Scores

Since the beginning of public schooling, students' skills have been measured by some type of testing. Invariably, the product of testing is a score, a "yardstick" by which an individual student is compared with others and/or by which progress is documented. Teachers and other educators use tests, and subsequently test scores, in a variety of ways: 1) to provide a "snapshot" or "profile" of the entire class in a given subject such as reading; 2) to identify students with specific strengths and weaknesses who might benefit from different instruction; 3) to sort out a group of students for additional testing or special help; 5) to evaluate the effectiveness of instruction; 6) to illustrate student progress over time; 7) to compare individual students or groups of students with some national or local standard.

Types of Tests and Test Scores

Most tests used in schools are either norm-referenced or criterion-referenced.

Norm-referenced tests compare an individual's performance to that of his or her classmates, thus emphasizing relative rather than absolute performance. Scores on norm-referenced tests indicate the student's ranking relative to that group. Typical scores used with norm-referenced tests:

- **Percentiles** A percentile is a score that indicates the *rank* of the student compared to others (same age or same grade), using a hypothetical group of 100 students. A percentile of 25, for example, indicates that the student's test performance equals or exceeds 25 out of 100 students on the same measure; a percentile of 87 indicates that the student equals or surpasses 87 out of 100 (or 87% of) students. Percentiles are derived from raw scores using the *norms* obtained from testing a large population when the test was first developed. Percentiles are probably the most commonly used test score in education.
- **Stanines** Stanines are essentially groups of percentile ranks, with the entire group of scores divided into 9 parts, with the largest number of individuals falling in the middle stanines, and fewer students falling at the extremes. Few tests in common usage use stanines today, although these scores can be useful in understanding the relative range of a student's performance.
- **Standard scores** A standard score is also derived from raw scores using the norming information gathered when the test was developed. Instead of reflecting a student's *rank* compared to others, standard scores indicate how far *above or below the average* (the "mean") an individual score falls, using a common scale, such as one with an "average" of 100. Standard scores also take "variance" into account, or the degree to which scores typically will deviate from the average score. Standard scores can be used to compare individuals from different grades or age groups because all scores are converted to the same numerical scale. Most intelligence tests and many achievement tests use some type of standard scores.
- **Age/Grade Equivalent scores** Some tests provide age or grade equivalent scores. Such scores indicate that the student has attained the same *score* (not *skills*) as an average student of that age or grade. For example, if Sally obtains a grade-equivalent score of 3.6 on a reading comprehension test, this means that she obtained the *same score* as the typical student in the sixth month of third grade. Sally may or may not have acquired the same skills as the typical third grader. Age/grade scores seem to be easy to understand but are often misunderstood and many educators discourage their use.

Standard scores, percentile ranks, and stanines can be compared using the "normal" or bell-shaped curve. Most tests used in education are developed in order to yield a standard curve of scores, where the majority of all students would fall within a small range (or one "standard deviation") of the mean or average score, and where 50% of all students would fall above, and 50% would fall below the average score. Some tests, however, do not have such "normal" distributions of scores and these different types of scores may not be comparable.

Criterion-referenced tests are used to measure student mastery of instructional objectives or curriculum (absolute performance), rather than to compare one student with another or to rank students. They are often used as end-of-unit tests in textbooks or as a "benchmark" to identify areas of strength or weakness in a given curriculum, readiness to move on to a different level of instruction, etc. Typically, *raw scores* are used to reflect the number of correct responses, the number of completed objectives, etc. Such tests will often use *percentages* to reflect the level of mastery of a given instructional objective, such setting a goal of "90% correct addition problems". Raw scores are converted to a percent correct.

Limitations of Test Scores

Scores can be useful, but must be interpreted carefully, keeping the purpose of the test in mind. A single test can only reflect a *sample* of skills; therefore, every score includes some degree of *error* in measurement— no score is absolutely accurate. Scores are influenced by many factors, but particularly by the *reliability and validity* of the test. *Reliable* tests will yield consistent results if administered many times. *Valid* tests actually measure and predict what they are intended to measure. For example, a valid reading decoding test will accurately distinguish students with strong and weak decoding skills; it will accurately predict which students will perform well in a phonics program and which students may have difficulty. We can place greater confidence in the scores provided by reliable and valid tests.

Many tests are of limited value when used with students who come from communities or cultures which are different from the White, middle class groups from which the scores are derived. Students who grow up in poor, rural or inner city communities, in ethnic minority families, or in families who primarily speak a language other than English are not typically well-represented in the standardization of tests, and scores obtained by these students often reflect some degree of bias.

Certain test scores are only useful for certain purposes, and not for others. **Percentiles and standard scores**, for example, are not intended to measure student growth. They only show relative standing compared to others, and this relationship does not necessarily change as students progress through the curriculum. **Raw scores**, such as words read correctly or number of multiplication problems solved correctly, can be plotted over time to reflect progress.

Limitations of test scores can be minimized by using other types of information to describe student performance. Test scores alone should never be used to make placement or other serious educational decisions. Observations, school and health history, parent information, daily work samples, etc. should be used in conjunction with test scores. Limitations of test scores can be further minimized by the use of qualified assessment personnel such as school psychologists to assist in the selection of tests and the interpretation of results.

How to Use Your Child's Test Results

Parents are often overwhelmed by the test reports they receive from school personnel. In order to help establish a true partnership between parents and teachers, it is essential that information about student progress be communicated clearly, respectfully, and accurately. You should expect your school to provide test results that follow these guidelines:

- Simple, clear language free from educational and test jargon
- Explanations of the purpose(s) of the tests used
- Brief descriptions of the test procedure(s)

- Scores appropriate to the test's purpose
- Clear explanations of the meaning of scores
- Information about the limitations of the test scores
- Corroborating information from other sources
- Opportunities for parents to ask questions about scores, testing, etc.
- Information about how the test results will be used

Raw scores and percentiles, when appropriate to the tests used, are generally the most easily explained and easily understood. A visual reference such as the figure above may also be helpful, particularly in explaining the concept of "average." Numbers can be misleading and in some cases frightening; it is important that you are given enough information to understand the limitations of any test or score and that you receive a comprehensive picture of your child's performance, not just test results.

Resources for Parents

Gellman, E. (1995). *School testing: What parents and educators need to know.* Westport, CT: Praeger.

Martin, M. & Waltman-Greenwood, C. (1995). *Solve your child's school related problems.* New York: HarperPerenniel. [see section on testing and test scores]

National
Association of
School
Psychologists

Understanding Test Scores

A Handout for Teachers

by Andrea Canter, Ph.D., NCSP
Minneapolis Schools

Background: Using Test Scores

Since the beginning of public schooling, students' skills have been measured by some type of testing. Invariably, the product of testing is a score, a "yardstick" by which an individual student is compared with others and/or by which progress is documented. Teachers and other educators use tests, and subsequently test scores, in a variety of ways: 1) to provide a profile of the entire class in a given subject such as reading; 2) to identify students with specific strengths and weaknesses who might benefit from different instruction; 3) to sort out a group of students for additional testing or special help; 5) to evaluate the effectiveness of instruction; 6) to illustrate student progress over time; 7) to compare individual students or groups of students with some national or local standard.

Types of Tests and Test Scores

Most tests used in schools are either norm-referenced or criterion-referenced.

Norm-referenced tests compare an individual's performance to that of his or her classmates, thus emphasizing relative rather than absolute performance. Scores on norm-referenced tests indicate the student's ranking relative to that group. Typical scores used with norm-referenced tests:

- **Percentiles** A percentile is a score that indicates the *rank* of the compared to others (same age or same grade), using a hypothetical group of 100 students. A percentile of 25, for example, indicates that thestudent's test performance equals or exceeds 25 out of 100 students on the same measure; a percentile of 87 indicates that the student equals or surpasses 87 out of 100 (or 87% of) students. Percentiles are derived from raw scores using the *norms* obtained from testing a large population when the test was first developed. Percentiles are probably the most commonly used test score in education.
- **Stanines** Stanines are essentially groups of percentile ranks, with the entire group of scores divided into 9 parts, with the largest number of individuals falling in the middle stanines, and fewer students falling at the extremes. Few tests in common usage use stanines today, although these scores can be useful in understanding the relative range of a student's performance.
- **Standard scores** A standard score is also derived from raw scores using the norming information gathered when the test was developed. Instead of reflecting a student's rank compared to others, standard scores indicate how far *above or below the average* (mean) an individual score falls, using a common scale, such as one with an "average" of 100. Standard scores also take "variance" into account, or the degree to which scores typically will deviate from the average score. Standard scores can be used to compare individuals from different grades or age groups because all scores are converted to the same numerical scale. Most intelligence tests and many achievement tests use some type of standard scores.
- **Age/Grade Equivalent scores** Some tests provide age or grade equivalent scores. Such scores indicate that the student has attained the same *score* (not *skills*) as an average student of that age or grade. For example, if Sally obtains a grade-equivalent score of 3.6 on a reading comprehension test, this means that she obtained the same score as the typical student in the sixth month of third grade. Sally may or may not have acquired the same skills as the typical third grader. Age/grade scores seem to be easy to understand but are often misunderstood and many educators discourage their use.

Standard scores, percentile ranks, and stanines can be compared using the "normal" or bell-shaped curve. Most tests used in education are developed in order to yield a standard curve of scores, where the majority of all students would fall within a small range (or one "standard deviation") of the mean or average score, and where 50% of all students would fall above, and 50% would fall below the average score. Some tests, however, do not have such "normal" distributions of scores and these different types of scores may not be comparable.

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Reporting Test Results to Parents

Parents are often overwhelmed by the test reports they receive from school personnel. In order to help establish a true partnership between parents and teachers, it is essential that information about student progress be communicated clearly, respectfully, and accurately. Test results should be provided to parents using:

- Simple, clear language free from educational and test jargon
- Explanations of the purpose(s) of the tests used

- Brief descriptions of the test procedure(s)
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Raw scores and percentiles, when appropriate to the tests used, are generally the most easily explained and familiar types of scores to report to parents. A visual reference such as the figure above may also be helpful, particularly in explaining the concept of "average." Numbers can be misleading and in some cases frightening; it is important for parents to understand the limitations of any test or score and to receive a comprehensive picture of their child's performance, not just test results.

Resources

The following texts provide an overview of assessment issues for educators, including test scores:

Gellman, E. (1995). *School testing: What parents and educators need to know.* Westport, CT: Praeger.

Hamill, D. (1987) *Assessing the abilities and instructional needs of students.* Austin, TX: Pro-Ed.

Salvia, J. & Ysseldyke, J. (1992) *Assessment in special and remedial education*, 5th edition. Boston: Houghton-Mifflin.

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Vocational and Transition Planning

A Handout for Parents and Teachers

by Gerald Hann and Edward M. Levinson, Ed.D.
Indiana University of Pennsylvania

Overview

Most parents and educators would generally agree that one of the primary goals of school is to prepare students for their eventual independent living in society. The school setting provides many opportunities for students to develop the academic and interpersonal skills they will someday need to function as productive citizens. Unfortunately many students' experiences at school do not always prepare them adequately for their eventual transition to a career. Often students find themselves choosing a career in an unplanned and often haphazard way. A more preferred method of preparing for a future career is a well planned transition plan.

Transition is ultimately concerned with the movement of a student from high school to post secondary training and from home to more independent living. An Office of Special Education and Rehabilitative Services (OSERS) document refers to transition as "a bridge between the security and structure offered by school and the opportunities and risks of adult life." A 1997 revision to the Individuals with Disabilities Act (IDEA) mandates that plans for a student's transition from school to work and community living must be included in the student's Individualized Education Program (IEP) by the time the student reaches age 14.

Although transition planning may have its roots in programs for students with disabilities it is apparent that all students could benefit from well defined programs of transition regardless of the existence of a disability. As today's job market becomes more competitive and unemployment rates continue to rise it makes good sense to plan for transition for students of all ages, not just those with disabilities or approaching graduation.

A clear plan for transition must also include vocational assessment and given the clear relationship between vocational assessment and transition planning, it makes little sense to discuss each separately. Successful transition planning cannot occur without the information gathered from a comprehensive vocational assessment. Conversely, information gleaned during vocational assessment is worthless if it is not tied directly to a well planned transition. The integration of vocational assessment and transition planning is the key to success.

Development

Although vocational assessment and transition may be focused upon more closely in the latter school years, it is beneficial if the process can begin as soon as students enter school and ideally the process should incorporate a K-12 career development plan. This does not mean that early elementary students should be subjected to in depth assessment batteries. It is more plausible that vocational assessment and transition in the early school years should encompass career exposure and educational activities geared to a level which is developmentally appropriate to younger students. For younger children it is important to emphasize the development of self-awareness, occupational awareness and good decision making skills. Early transition planning is also an excellent opportunity for educators and parents to introduce non-traditional employment opportunities and thereby dispel gender bias as it relates to children's understanding of traditional and non-traditional employment roles. As students approach the middle and secondary school level the need for a more formalized vocational assessment occurs.

Vocational/Transition Assessment

In implementing a transition service as part of a comprehensive assessment and transition plan, several important principles should be followed. Parents and teachers involved in facilitating the student's transition should consider the developmental maturity of the student as well as the skills that the student will need to adjust to community living and employment. The skills that should be considered include such things as daily living skills (e.g., managing money, preparing food), personal/social skills (e.g., hygiene, social skills), and occupational/vocational skills (e.g., job-seeking skills and appropriate work habits). The degree to which the student already possesses these skills and the extent to which these skills need to be developed can be determined in part by the vocational assessment. Vocational assessment should be more formalized as the student moves through grade levels and the assessment information gathered in later years should be multi-level and include assessment at both the junior and senior high levels.

It is crucial that the process of transition and vocational assessment is developed in a systematic and logical fashion. A variety of transition models exist, but most of these emphasize similar components including personal consideration of the student (e.g., disability, developmental maturity), the goal of integration into the community and a partnership with a variety of agencies. On-going collaboration between parents and teachers is also a key component of the process.

In developing a transition plan it is also important to determine what support services and agencies are available to the student in the community and how these agencies can become an integral component in the transition process. It is desirable to identify such agencies early in the transition process and to encourage interagency involvement on an on-going basis throughout the transition process. When considering liaisons with community partnerships it is advisable to investigate what types of services are readily available in the community. It would be unrealistic to develop a transition plan which hopes to utilize services which are unavailable in the community. It is also a good idea to consider local employment options as they relate to the student's needs and to determine if competitive, sheltered or supportive employment is most appropriate.

One final concern regarding vocational assessment and transition that needs to be considered relates to the people who should be involved in implementing the program. Ideally the process should be on-going throughout the student's school career and include a partnership of all who have a stake in helping the student succeed. This partnership may include parents, regular and special education teachers, school administrators, counselors and vocational specialists, community professionals and the school psychologist.

Developing the Functional Curriculum

Once the level of skill possessed and needed by the student has been identified in the initial portion of the transition program, it is appropriate to address the identified skills in the school curriculum. This can be described as the "development of a functional curriculum" and it is during this phase that consideration should be focused on developing skills to address the needs identified by the vocational assessment. A functional curriculum can be best described as one which meets the needs of students across their life span and in a variety of settings. For example, an ADHD teenager may require support in developing social skills as they relate to personal and vocational goals or a high school student with an intellectual impairment might need assistance in developing personal hygiene and community living skills.

Planning for a student's eventual transition into the work place cannot be left to chance. Students nowadays require guidance and expertise in helping to plan for their careers and eventual life as independent members of our society. Indeed as the global market place grows and job prerequisites continue to become more rigorous it is essential that parents and educators assist students as much as possible in planning for their future. Undoubtedly, a thorough understanding of vocational assessment and transition planning is an essential component in assisting students in reaching their potential.

Resources for Parents and Students

Kimbrell, G. & Vineyard, B.S. (1978). *Entering the world of work.* Bloomington, IL: McKnight (text appropriate for use with junior and senior high school students).

Otto, L.B. (1984). *How to help your child choose a career.* New York: Evans (written for parents of high school age).

Rettig, J.L. (1986). *Careers: Exploration and decision making.* Belmont, CA: David S. Lake (appropriate for use with high school students).

Technical Assistance Center for Special Populations Program (TASPP), the National Center for Research in Vocational Education, Dept. of Vocational and Technical Education, The University of Illinois, 345 Education Building, 1310 South Sixth St., Champaign, IL 61820. Dr. Carolyn Maddy-Berstein, Director. (Resource center which provides materials on transition to parents and professionals.)

Resources for Educators

Kapes, J.T., Mastie, M.M. & Whitfield, E.A. (1994). *A counselor's guide to career assessment instruments (3rd ed.).* Alexandria, VA: National Career Development Association.

Levinson, E.M. (1993). *Transdisciplinary vocational assessment: Issues in school-based programs.* Brandon, VT: Clinical Psychology.

Levinson, E.M. (1995). Best practices in transition services. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology—III* (pp. 905-915). Bethesda, MD: National Association of School Psychologists.

NATIONAL
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PSYCHOLOGISTS

What Is a School Psychologist?

Information for Parents

by The National Association of School Psychologists

Who Are School Psychologists?

Today's children face more challenges than ever before. School psychologists help children meet these challenges through their specialized training in both psychology and education. They use their training and skills to team with educators, parents and other mental health professionals to ensure that every child learns in a safe, healthy and supportive environment. School psychologists understand school systems, effective teaching and the ingredients for successful learning.

The training requirements to become a school psychologist are a minimum of 60 graduate semester hours including a year-long internship. This training emphasizes preparation in mental health, child development, school organization, learning, behavior and motivation. To work as a school psychologist, one must be certified and or/ licensed by the state in which services are provided. School psychologists also may be nationally certified by the National School Psychology Certification Board (NSPCB).

What Do School Psychologists Do?

School psychologists tailor their services to the particular needs of each child and each situation. School psychologists use many different approaches and may play many different roles, but most provide these core services:

Consultation

- give healthy and effective alternatives to teachers, parents, and administrators about problems in learning and behavior
- help others understand child development and how it affects learning and behavior
- strengthen working relationships between educators, parents and community services

Assessment

Use a wide variety of techniques at an individual, group, and systems level to evaluate:

- academic skills and learning aptitudes
- personality and emotional development
- social skills
- learning environments and school climate
- eligibility for special services

Intervention

- work face-to-face with children and families
- help solve conflicts and problems in learning and adjustment
- provide psychological counseling for children and families
- provide social skills training, behavior management, and other strategies
- help families and schools deal with crises such as death, illness or community trauma

Prevention

- identify potential learning difficulties
- design programs for children at risk of academic failure
- provide parents and teachers with the skills to cope with disruptive behavior
- help foster tolerance, understanding and appreciation of diversity in the school community
- develop school-wide initiatives to make schools safer and more effective

Education

Develop programs on topics such as:

- teaching and learning strategies
- classroom management techniques
- working with students who have disabilities or unusual talents
- substance abuse
- crisis management

Research and Planning

- evaluate the effectiveness of academic programs, behavior management systems and other services
- generate new knowledge about learning and behavior
- contribute to planning and evaluating school-wide reform and district-wide policies

Health Care Provision

- collaborate with school and community-based personnel to provide a comprehensive model of school-linked health services
- work with children and families to provide integrated community services focusing on psychosocial wellness and health-related issues
- develop partnerships with parents and teachers to create healthy school environments

Where Do School Psychologists Work?

The majority of school psychologists are employed in public and private school systems. However, school psychologists practice in a variety of settings including:

- public and private schools
- school-based health centers
- clinics and hospitals
- private practice
- university, community and state agencies, and other institutions

Growing Up Isn't Easy

All children and adolescents face problems from time to time. They may:

- have fears about starting school
- be upset about family events such as divorce and death
- feel depressed
- lack self-discipline
- experiment with drugs or alcohol
- think about suicide
- lack study skills
- worry about their sexuality
- consider dropping out of school

School psychologists are there to help parents, educators, and the community understand and solve these and many other problems. By dealing with learning problems early on, school psychologists can help prevent further difficulties. They recognize that changes in school and home environments can improve the quality of life for children and family members. They can be trusted to deal in confidence with sensitive personal and family matters. School psychologists understand how schools work and how children learn; provide easily accessible, cost-effective mental health services to children; and promote positive mental health and a safe and effective learning environment.

The National Association of School Psychologists represents more than 24,000 school psychologists and related practitioners who serve the education and mental health needs of children, adolescents, young adults and families. For more information, contact the psychologist serving your school or NASP at (301)657-0270.

NATIONAL
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¿Qué Es Un Psicólogo Escolar?

Información Para Padres

¿Quiénes Son Los Psicólogos Escolares?

Los psicólogos escolares poseen adiestramiento especializado tanto en psicología como en educación. Ellos utilizan su adiestramiento y destrezas para colaborar con los educadores, padres y otros profesionales de salud mental para asegurarse de que cada niño aprenda en un ambiente segur y saludable donde se apoye su proceso de desarrollo. El psicólogo escolar conoce sobre el sistema educativo, la enseñanza efectiva y el aprendizaje exitoso. Hoy en día los niños enfrentan más retos que nunca antes. Los psicólogos escolares pueden proveer soluciones para los problemas del mañana a través de actos positivos y bien intencionados realizados en el día de hoy.

El adiestramiento requerido para ser un psicólogo escolar es de un mínimo de 60 créditos graduados, además de un año de internado. Este adiestramiento enfatiza la preparación en salud mental, desarrollo del niño , organización escolar, aprendizaje, comportamiento y motivación. Para poder trabajar como psicólogo escolar, se debe estar certificado o tener una licencia del estado o país en que los servicios han de proveerse. Además, puede estar certificado a nivel de los Estados Unidos por la Junta de Certificación Nacional en Psicología Escolar (NSPCB, por sus siglas en inglés).

¿Qué Hacen Los Psicólogos Escolares?

Los psicólogos escolares ajustan sus servicios a las necesidades y situaciones particulares de cada niño. Los psicólogos escolares usan acercamientos diversos, pero la mayoría provee los siguientes servicios básicos:

Consultaría/Asesoramiento:

- Proveer a los maestros, padres y administradores alternativas saludables y efectivas en torno a los problemas de aprendizaje y comportamiento
- Ayudar a otros a comprender el desarrollo del niño y como éste afecta el aprendizaje y el comportamiento
- Fortalecer las relaciones de trabajo entre educadores, padres y proveedores de servicios en la comunidad

Evaluación:

Uso de amplia variedades es de técnicas a nivel individual, grupal y sistemático para evaluar:

- Destrezas académicas
- Aptitud hacia el aprendizaje
- Desarrollo personal y emocional
- Destrezas sociales
- Ambiente para el aprendizaje y clima escolar
- Elegibilidad para la obtención de servicios especiales

Intervención:

- Trabajar frente a frente con las familias de los niños.
- Ayudar en la solución de conflictos y problemas que se desarrollan en el ajuste y el aprendizaje
- Proveer consejería psicológica a los niños y sus familias

- Proveer adiestramientos en destrezas sociales, manejo del comportamiento y otras estrategias
- Ayudar a las familias y las escuelas a manejar crisis, tales como separación y pérdida

Prevención:

- Identificar dificultades potenciales en el aprendizaje
- Diseñar programas para niños en riesgo de fracasar
- Proveer a los padres y maestros las destrezas para hacer frente a conductas desorganizadas
- Ayudar a promover la tolerancia, comprensión y aprecio de la diversidad en la comunidad escolar
- Desarrollar iniciativas en el ámbito escolar para hacer las escuelas más seguras y efectivas

Educación:

Desarrollar programas sobre temas tales como:

- Estrategias de enseñanza-aprendizaje
- Técnicas en el manejo del salón
- Trabajo con estudiantes impedidos o con talentos poco comunes
- Abuso de sustancias controladas
- Manejo de crisis

Investigación y Planificación:

- Evaluación de la efectividad de los programas académicos, sistemas de manejo de conducta y otros servicios
- Generar nuevos conocimientos acerca del aprendizaje y el comportamiento
- Contribuir a la planificación y evaluación de la reforma y estructuración escolar

Provisión de Cuidados de Salud:

- Colaborar con la escuela y el personal de la comunidad para proveer un modelo amplio sobre los servicios de salud escolares
- Trabajar con los niños y sus familias para proveer servicios públicos dirigidos al bien psico-social y a asuntos relacionados con la salud
- Desarrollo de vínculos con los padres y los maestros con el fin de crear ambientes escolares saludables

¿Dónde trabajan los psicólogos escolares?

La mayoría de los psicólogos escolares están empleados por los sistemas escolares privados y públicos. Además, los psicólogos escolares trabajan en una variedad de lugares, entre ellos:

- Centros de salud ubicados en las escuelas
- Clínicas y hospitales
- Práctica privada
- Universidad, comunidad, agencias estatales y otras instituciones

Crecer No Es Fácil:

Todos los niños y adolescentes confrontan, de vez en cuando, problemas. Ellos pueden:

- Sentir temor al inicio de clases
- Manejar su tiempo pobremente
- Exhibir rezagos en su trabajo escolar

- Estar preocupados por sucesos familiares tales como el divorcio y la muerte
- Sentirse deprimidos
- Carecer de auto-disciplina
- Experimentar con drogas y alcohol
- Pensar sobre el suicidio.
- Sentir preocupación sobre la sexualidad
- Enfrentar una decisión difícil sobre el colegio o trabajo
- Considerar darse de baja de la escuela
- Desconocer sus habilidades y aptitudes.

Los psicólogos escolares están ahí para ayudar a los padres, educadores y a la comunidad para que entiendan y resuelvan estos problemas.

Los psicólogos escolares:

- Entienden cómo funciona el sistema escolar y cómo aprenden los niños
- Proveen servicios de salud mental económicos y de fácil acceso a los niños
- Promueven una salud mental positiva y un ambiente de aprendizaje efectivo y seguro

La Asociación Nacional de Psicólogos Escolares representa a más de 20,000 psicólogos escolares y profesionales en áreas relacionadas, que atienden las necesidades de salud mental y educativas de niños, adolescentes, jóvenes, adultos y familias.

Para más información, comuníquese con la:

La Asociación Nacional de Psicólogos Escolares
(NASP, por sus siglas en inglés)
4340 East West Highway, Suite 402
Bethesda, MD 20814
301-657-0270 (voice)
301-657-0275 (fax)
301-657-4155 (TDD)
e-mail: *<NASP8455@aol.com>*
World Wide Web: *<http://www.nasporg.web>*

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Academic Motivation

A Guide for Teachers

Instruction/Curriculum

**by Michael B. Brown, Ph.D., East Carolina University (NC)
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What is Academic Motivation?

Academic motivation is a student's desire to learn, engage in learning-related activities, and find school-related activities meaningful. Usually we want to help develop students' intrinsic motivation — a desire to perform well in the classroom because it is important and rewarding for the student.

The Development of Academic Motivation

The push to master the environment emerges in infancy, and can be clearly seen in a baby's struggle to reach a desired object, learn to walk or eat without help. This mastery motivation seems to set the pace for later motivation to learn in other areas, including school. When children are not motivated to learn, something has interfered with their natural motivation. They develop the belief that they cannot do well in school-related tasks, and therefore do not exert the effort necessary to do so. They become easily frustrated and do not persist when tasks become difficult. They also do not get to experience the thrill of learning a new concept or skill, as they are likely to not try (guaranteeing failure) or attribute any success to luck or circumstance.

What factors can contribute to this negative belief system? Learning disabilities, difficult temperament or neurodevelopmental delay, depression or chronic life stressors may interfere with a student's ability to do schoolwork effectively. Children with a history of school failure are very likely to stop trying to learn because of the developing belief that they cannot do so. Environmental factors also influence the academic motivation of all students, not just students with difficulties. When students start in elementary school, their expectations for their performance in school are usually very high. They also consider effort to be the difference between low performance and high performance in school. Individualized competition in school (where someone always wins and someone always loses) and excessively high standards for performance are very discouraging to children, especially those who will never be "the best" at school. The lack of reinforcement or experience of success also contributes to poor academic motivation. Additionally, some children come from homes where reading, achievement or intellectual pursuits are not a part of their family life, or, even worse, objects of scorn and ridicule. Their parents may have experienced failure in school and may thus have low expectations for their children or negative feelings about schooling.

Motivation is a complex phenomenon, but there are a number of ways that teachers can influence their students' academic motivation. Fostering good student-teacher relationships, changing instructional practices and classroom organization techniques can all contribute to helping enhance academic motivation.

Teacher-Student Interactions That Enhance Academic Motivation

- Work to establish a warm, caring relationship with all students. Being in an atmosphere that is supportive enhances motivation by decreasing the fear of failure.
- Communicate your concern, acceptance and empathy for the plight of students who are not academically motivated. Frequently a side effect of poor academic motivation is to feel that teachers do not like them and, often, children with poor academic motivation may be viewed in a nega-

tive light. Go out of your way to communicate otherwise. And keep at it, even if the student doesn't respond or says he "doesn't care." Often it has taken a long time for this pattern to develop, and it may take some time to turn it around.

- Model for students enthusiasm, love for learning, and effective learning and organizational strategies.
- Maintain high but realistic expectations for student performance throughout their academic career. All children can learn.
- Focus on effort, not ability, when talking to students about academics. Many students believe that the key to doing well is ability. It is important that students understand that the key to learning is really effort and practice. When students are successful, focus on what they did to be successful. When they do not succeed, have them focus on what they could do differently to be a more effective learner.
- Help students set specific, proximal goals for learning. Their goals should be challenging yet achievable.
- Have students identify their long-term life goals, and let them see the connection between learning now and reaching their long-term goals. Encourage them to have a challenging and realistic view of what they can aspire to for the future.
- Give specific feedback to students on how they are doing in meeting their learning goals.

Enhancing Academic Motivation Through Classroom Organization

- Develop classroom routines that provide some structure for students and that creates a comfortable and predictable classroom environment.
- Recognize students for what they have learned (how they have improved), not for being better than other students.
- Grade in a way that emphasizes learning rather than performance. Don't grade "on the curve" as this means only a few students can do well. Don't make individual students' grades public.
- Teach learning and study strategies to your students. Often lack of strategies is what contributes to difficulties in learning, which in turn contributes to decreased motivation.
- When using rewards, be specific about what the student has done well. Present the reinforcement *after* the student's successful performance, and in such a way as to let students know they are rewarded for learning, not working for rewards.

Instructional Practices That Increase Academic Motivation

- Arrange for students to have successes in their classroom work. This is especially true for the child who is already academically discouraged. Children must experience success to begin to believe that they can be successful.
- You may have to individualize instructional practices for students who are significantly behind or not able to do well because of their learning problems. Altering the rate of instruction, the method of instruction, or the amount of work may be necessary.
- Use cooperative learning strategies to emphasize learning rather than individual competition. Students should work face-to-face in small groups in which they must all contribute to the final learning product.
- Stimulate cognitive conflict through the use of debates, looking for alternative methods of solving problems, encouraging classroom discussion, and having students predict the outcome of learning activities.

- Make learning tasks more interesting by including action in your lessons. Projects, case studies and role-playing are all ways to increase interest in learning activities.
- Tell students the objective of lessons and activities. Help them to know in advance what to expect and where to focus their attention.
- Let students include their areas of interest in your assignments. If you want a student to learn to read better, then let the student read about a special area of interest such as baseball. If you are teaching math, have a student who is interested in being a fireman learn to calculate pump pressure for fire equipment.
- Help students to relate what they are learning in the classroom to their interests and their "real life."

Resources

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Academic Learning Time

A Handout for Teachers

by Maribeth Gettinger, Ph.D.
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Overview

The amount of time during which students are learning from group lessons or individual study is called productive, active or, most commonly, academic learning time (ALT). Only a fraction of the total amount of time allocated for instruction, sometimes as little as 25%, is actually spent in learning. Recent effective-teaching research has shown that when students' ALT is increased, a concomitant increase in achievement will likely occur, especially for low-achieving students. Furthermore, ALT is considered to be a manipulable facet of classrooms, one resource that teachers can control through effective teaching and managerial practices.

To plan strategies for increasing ALT, it is necessary to first analyze how time is used. Teachers can keep logs of how time is allocated and used during a typical day or week. Such a time-profile assessment enables teachers to focus efforts directly on time components that need improvement. Learning time is composed of four components: (a) allocated time, which may be reduced by interruptions, transitions and other non-instructional activities; (b) instructional time, which may be only 50% to 90% of allocated time and is further reduced by students' inattentiveness and disruptiveness; (c) engaged time, typically 45% to 90% of instructional time and often reduced by inappropriate instruction; and (d) ALT, ranging from 40% to 90% of engaged time.

What Can I Do as a Teacher?

Based on this analysis of learning time and an assessment of time use within each component, teachers can increase ALT in three general ways: (a) increase the proportion of allocated time that is actually used for instruction; (b) work to increase on-task or engaged time among students; and (c) enhance the productivity of learning time by matching instruction to individual needs and monitoring performance.

Increase Instructional Time

Teachers who are task-oriented and who plan and organize their teaching activities use more daily allocated time for actual instruction than teachers who do not plan as carefully. Effective time-management strategies for increasing instructional time include:

Establish Contingencies for School Attendance and Punctuality

- Reinforce attendance and punctuality consistently through praise, points, monthly certificates, or within-class competition.
- Structure classroom routines so that being present and on time are expected, e.g., give instruction for daily activities only once at the start of a class session.
- Adhere to a strict daily schedule; start and stop classes or lessons exactly on time.

Minimize Interruptions

- Schedule specific times for managerial, noninstructional activities, e.g., collecting money, cleaning up, making announcements.

- Limit students' disruptiveness and the number of teacher reprimands for misbehavior; misbehavior can be minimized by establishing explicit rules for behavior and consistent consequences for compliance and noncompliance with rules.

Facilitate Smooth Transitions

- Develop, teach and practice step-by-step procedures for activity shifts.
- Provide brief verbal cues, rather than lengthy instructions, for activities.
- Prepare all materials for each activity before the day begins.
- Reinforce smooth, quick transitions, e.g., time students during activity shifts and have them compete with one another or against a predetermined criterion.

Maintain a Strong Academic Focus

- Allocate group time for academic subjects and schedule short time blocks for individualized practice for students who require extra time.
- Use peer tutors or parent volunteers to provide additional academic review time.
- Schedule preferred activities immediately after less preferred ones; important activities should occur during students' peak levels of attending and functioning.
- Consider the benefits of block scheduling. With secondary students in particular, this would require a school-wide commitment. Block scheduling allows more time for guided practice, enhancement of lessons and peer tutoring; it also helps disorganized students as they have less to organize during the day.

Increase Engaged Time

Teachers who exhibit structured, interactive, fast-paced and directive teaching styles have students who are more highly engaged in learning. Teaching behaviors that maximize attention during whole-group instruction as well as independent seatwork include:

Clarify Instructions and Performance Expectations

- Have students write, repeat or paraphrase task directions to ensure understanding; post classroom rules.
- Keep task instructions worded simply and few in number; include precise statements of what students are expected to do.
- Break tasks down into small segments and demonstrate steps for completing assignments.
- During independent seatwork, move throughout the classroom monitoring children, praising students who follow directions and administering consequences for those who do not comply.

Maintain an Interactive Teaching Style

- Include all students in discussions and provide frequent opportunities for student responding, e.g., choral responding, calling on students, asking students to comment on others' responses.
- Use fast-paced, teacher-directed instruction and practice.
- Maintain optimal difficulty level of instruction and questions to ensure that responding and feedback are primarily positive.

Adopt Seating Arrangements to Encourage Attending

- Use seating that permits visual contact with all students.
- Use arrangements that minimize auditory distractions.
- Move around the room continuously, going to students rather than having students come to the teacher.

Increase Productive Learning Time

Although increasing instructional time and maintaining student engagement are important, the overall quality of teaching during instructional or engaged time and the appropriateness of instruction for individual students affect the amount of ALT that students receive. Students who attain high levels of productive learning time are likely to achieve more than students who accumulate less time. Guidelines for enhancing the quality of instruction include:

Use Seatwork Effectively

- Monitor seatwork by moving around the room systematically; keep contacts with individual students brief.
- Establish clear procedures about what students should do when work is completed; have alternative activities for fast students (e.g., working in the classroom as peer tutors).
- Develop a procedure for requesting and obtaining assistance that is not disruptive and allows students to continue working while they wait, e.g., an assistance report card attached to desks that students use to signal the teacher.

Provide Immediate, Corrective Feedback

- Feedback should indicate whether responses are correct and provide suggestions for reworking incorrect problems.
- Strive for greater frequency, specificity and academic relevance in corrective feedback.
- To minimize time demands, correct students' work while circulating during seatwork periods, use self-correction, or have students correct each other's work.

Diagnose, Prescribe and Monitor Performance Accurately

- Assess students' current knowledge, skill level and strengths and weaknesses to determine appropriate instructional goals, task difficulty, grouping and scheduling.
- Monitor students' performance during actual instruction, e.g., accuracy of responding when students are engaged in group or individual learning.

Resources

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An Anti-Bias Approach to Early Childhood Education

A Handout for Teachers

by Ann L. Boyd
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Overview

By the year 2000, it is predicted that one out of three Americans will be a person of color and at least fifty American cities will be predominately non-white. As our society becomes increasingly more complex and diverse we must prepare our children to grow up with the attitudes, knowledge and skills necessary to live competently within this diverse world. A child's sense of identity and awareness of differences begins very early in the preschool years. Research in this area suggests that children learn by observing differences and similarities among people and by absorbing the spoken and unspoken messages about those differences.

A comprehensive curriculum approach that will help empower children to develop an awareness, respect for and appreciation of self and others is reflected in an Anti-bias Curriculum. Anti-bias curriculum incorporates the positive intent of multi-cultural curricula while expanding to include other forms of bias, stereotypes and misinformation. Anti-bias curricula not only address race and ethnicity but also include gender, language, religious diversity, sexual orientation, physical and mental ableness and social and economic class. In contrast to some multi-cultural curricula, anti-bias curriculum is a proactive, problem solving approach that is integrated into all aspects of existing curriculum and the everyday environment. This lessens the likelihood of becoming a "tourist curriculum," an approach that can trivialize and patronize a culture by focusing on differences and on surface aspects of their celebrations and artifacts.

The goals of anti-bias curricula are to "enable every child to construct a knowledgeable, confident self identity; to develop a comfortable, empathetic and just interaction with diversity; and to develop critical thinking and the skills for standing up for oneself in the face of injustice" (Derman-Sparks, 1989, p. ix). Anti-bias curriculum recognizes not only the need of each child to be seen as a valued individual but also the importance of each child's ability to view others in the same vein.

What Can I Do as a Teacher?

Examine Your Own Biases and Explore Your Life History

This very first step is often the most difficult and yet it is also the most crucial aspect of an anti-bias approach. Children's learning style, values, self concept and social competence are influenced by the culture, opinions and attitudes of their family and other primary caregivers. By the time they reach kindergarten, children are very aware of differences and much of this knowledge appears to be transmitted through family and the media. The role of the early childhood teacher is crucial and it is essential that teachers be actively reevaluating their own biases and disposition.

Keep Yourself Informed, Do Research and Acquire Accurate Information

Children are as vulnerable to omissions as they are to inaccuracies and stereotypes. Stereotypes can be nourished by lack of information. Be sure to provide them with accurate, non-biased information about all groups. It is not the differences themselves that cause problems but how people perceive and respond to these differences. Recognize and acknowledge all forms of diversity.

Children Need to Experience Diversity Outside Their Immediate Environment

Do not be limited to the diversity within the classroom or the community. Engage in conversations about diversity. Find similarities between people and focus on what people have in common, not just what there is between them that is different.

Everyone Has a Culture, Not Just Those Who Appear Different

Children who are taught to appreciate and understand their own culture learn to understand other cultures in the process. Every family has its own traditions and style.

Promote Positive Self-concept

Nurture the self-esteem, self-worth and sense of dignity of each child and their families.

Be Accepting of All Children

Expect to Run Into Resistance

Anti-bias curriculum is a process that will continually evolve and grow. These changes require courage and risk-taking. Form a support group with other teachers who are implementing anti-bias curriculum. Share ideas and problem solve together. As with bias, resistance often results from lack of knowledge. Explain to those who are resistant why you are implementing the anti-bias curriculum.

Examine, Challenge and Work to Eliminate Institutional Bias

Anti-bias curriculum is also about social change. Continually examine policies and practices not only in the classroom but in the school and community at large.

What Strategies Can I Use in My Classroom?

Evaluate the Classroom Environment Regarding its Messages for Diversity.

Look Critically at All the Materials in the Classroom.

Create a Picture File

Include a fair balance of images of different races, differently abled people doing a variety of activities, different ages of people performing different tasks, diversity of family styles, and men and women in nontraditional roles. Display these pictures around the room. Display photographs of the children, their families, people within the community, and the staff.

Reevaluate the Books in the Classroom

Make sure the books reflect diversity of gender roles, racial and cultural backgrounds, special needs and abilities, a range of occupations, a range of ages, a range of incomes, varying lifestyles and different languages. If biased books are a part of your library, use them as a teaching tool.

Music

Expose the children to music of various styles and cultures. Include jazz, reggae, classical, Native American , Indian classical , children's lullabies, music for movement and dancing, and music for singing as just a few ideas. Play some of the different types of music during free choice time, not just during music time.

Art Materials

Include skin tone crayons, markers and paints as well as multi-cultural paper. Allow children to look into mirrors when making self portraits. Encourage the children to make pictures of each other as well as their families. Note if the children include their glasses, wheelchairs, etc. in their pictures.

Housekeeping and Dramatic Play

Include dolls that represent a fair balance of all the major groups in the United States. Try supplementing commercial dolls with homemade dolls. Have the children make some dolls as a project. Include tools used by people with various special needs such as crutches, braces or glasses in the housekeeping area. Create play rooms other than a kitchen, such as work rooms with tools.

Manipulatives

These should also depict diversity in race, gender, physical abilities and occupations. Take care when ordering materials to avoid stereotypical images.

Active Problem-solving

Learn what ideas the children have about diversity. Ask the children questions and present problem solving activities and role playing. Provide honest, accurate responses to the children and help teach them how to recognize and deal with injustice. Learning about diversity and equity should permeate all activities. These conversations are particularly effective during circle time but "teachable moments" occur throughout the day. Jump right in if you hear children carrying on a biased conversation and help them explore the realities of what they are saying.

Inform, Engage and Involve Parents

Organize a parent meeting and inform the parents about why anti-bias is a part of the curriculum and how it is being implemented. Plan a parent education session about how children develop identity and attitudes. Most importantly, invite the parents to participate. Parents are an invaluable resource and can help bring the strengths of their unique families into the classroom. Remember how difficult it may be for some parents to take that first step and look at their own biases. It is important not to alienate those parents who may have more difficulty accepting the anti-bias principles.

Resource

Derman-Sparks, L., & A. B. C. Task Force. (1989). *Anti-bias curriculum: Tools for empowering young children.* Washington, D.C.: National Association of Young Children. (Accompanying video is also available from the National Association of Young Children, NAEYC, 1834 Connecticut Ave. NW, Washington, D.C. 20009)

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Cooperative Learning in the Classroom

**by Linda Metzke, Lydon State College
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Collaborative Learning Versus Cooperative Learning

The confusion and disagreement about the differences between cooperative and collaborative learning stems from the history of the two approaches. Cooperative learning, largely with American roots, is based on the philosophical writings of John Dewey stressing the social nature of learning and Kurt Lewin's work on group dynamics. Collaborative learning, which has British roots, is based on the work of English teachers exploring ways to help students respond to literature by taking a more active role in their own learning.

The underlying premise of *collaborative learning* is consensus building through cooperation by group members. There is a sharing of authority and acceptance of responsibility among group members for group actions. In contrast, *cooperative learning* is defined by a set of processes designed to teach people to interact in order to accomplish a specific goal or develop an end product which is usually content specific. Cooperative learning is more directive than a collaborate system of governance and closely controlled by the teacher. The fundamental approach of cooperative learning is teacher centered, whereas collaborative learning is more student centered. Those teachers just getting started may want to focus on mastering the skills and techniques of cooperative learning which can be applied in more collaborative settings as teachers' skills and belief systems develop. Cooperative learning is also more appropriate for younger students and students just learning to work cooperatively.

Overview of Cooperative Learning

Different developers of cooperative learning (CL) come from different perspectives and take different approaches to CL. Slavin, Johnson and Johnson, and Kagan all have slightly different approaches to cooperative learning. Johnson and Johnson focus on developing a specific structure that can be utilized across the curriculum in a variety of situations. Their focus is the integration of social skills and academic tasks. Kagan's work focuses on the utilization of many different structures designed to facilitate active learning, team building and group skills. Slavin's work includes developing student teams-achievement divisions (STAD) , teams-games-tournaments (TGT), team assisted individualization (TAI) and cooperative integrated reading and composition (CIRC) which utilize methods from both Kagan and Johnson and Johnson.

Common Characteristics

- Students work in small groups (2-5 people) to accomplish a task.
- Steps are taken to make certain each person participates — the task is designed so it can be completed only if each person does his/her job.
- Individual accountability — learning is measured separately for each participant.
- Group interdependence is established through role assignment, jigsawing of materials, or task design.
- Social/group skills are taught directly and practiced during the group work.
- Teachers monitor student groups during group work and intervene to help groups accomplish the goals or function more effectively.
- Students are involved in a process of active learning which allows them to take control of their learning.

- Heterogeneous groups work together and enhance each other's learning.
- Provides opportunities for peer tutoring as well as enrichment for talented students.

Benefits of Cooperative Learning

- Develops higher level thinking skills and learning in general.
- Students remember information and processes they have explained to others.
- Promotes active learning and the development of an internal locus of control.
- Promotes student-student and student-teacher interaction.
- The cooperative process enables the teacher to move around the class in order to observe students interacting.
- Increases student retention. Students who are actively involved in the learning process are much more likely to become interested in learning and make more of an effort to attend school.
- Builds self esteem in students — CL results in a higher degree of accomplishment by all participants as opposed to individual, competitive systems in which many students are left behind.
- Enhances student satisfaction with the learning experience.
- Promotes a positive attitude toward the subject matter.
- Encourages friendships between students across racial, socio-economic, ability and gender lines.
- Encourages students to set learning rather than performance goals, i.e., learn the material instead of do better than others.
- Helps students develop life skills in communication and collaboration.
- Allows students to share learning strategies and "learn to learn."
- Promotes psychological health through teaching acceptance of self and others.
- Encourages students to become problem solvers and critical thinkers.
- Provides a forum for specific student abilities in art, music, thinking.
- Provides for ongoing assessment of student learning.
- Gives students an opportunity to evaluate progress both as a group and as a group member.
- Gives students an opportunity to develop rubrics for their own work.
- Allows students to learn conflict resolution skills.

Benefits of CL in the Inclusive Classroom

- Encourages the development of collaborative relationships between special and regular education teachers.
- Uses heterogeneous groups where special needs students can be given a role that utilizes their strengths.
- Teaches helping skills to all students.
- Provides for different evaluation systems for individual students such as different criteria, different materials, different amount. Allows for evaluation by means of improvement scores.
- Helps students with special needs become active learners through peer role models.
- Gives special needs students the opportunity to develop needed social skills.
- Facilitates the development of curriculum adaptations.
- Allows for individual attention.
- Provides a way for teachers to capitalize on the opportunities provided by longer class periods and block schedules.

Concerns/Issues

Classroom management: Teachers need to have effective control of their classrooms. It is easy for students to get off-task — especially when the teacher is new to CL and relatively unskilled in group management.

Age level: The basic approaches are similar with elementary and secondary students. Younger students may need more training in social skills to work well in groups, i.e. how to listen, take turns, disagree respectfully, follow instructions. Then again, many secondary students may benefit from skill development in this area. CL activities can be designed to teach social skills as well as academic ones.

Student attention: Teachers need a method for bringing the class to attention. A hand signal is often used for the purpose. Some teacher use a bell or other sound making device to quickly obtain the attention of the class.

Comfort level: Some students are resistant to sharing ideas and are uncomfortable working in a group structure.

Suggestions for Implementing Cooperative Learning

- Start small with pairs and very simple tasks and structures such as *Think-pair-share* — see Kagan.
- Begin with a small activity that takes only a few minutes and, as students become more skilled with group work, activities can become more complex and longer.
- Become skilled at one structure or task before trying others.
- Build heterogeneous groups
- Teach (role play, demonstrate, discuss) the target social skill before the groups begin to work.
- Monitor the groups as they work. Do not expect peer pressure to solve group problems.
- Encourage students to reflect on and evaluate their work as a group. Groups should be able to explain what they can do to improve their group work. Johnson and Johnson refer to this as "processing."
- Develop activities that require critical thinking and problem solving.
- Divide the academic task so everyone can contribute.
- Provide closure to the activity.
- Go to workshops, develop a peer support group, observe experienced practitioners.
- If you don't like one approach, check out some of the other ones.

Remember, learning how to effectively use CL is one of the toughest, if not the toughest, changes a teacher can make. Be kind to yourself. You will be learning right along with your students. Remember that according to Robert Slavin, "Cooperative learning is a natural for constructivist models of teaching and is almost always a part of constructivist approaches. In fact, much of the theory underlying cooperative learning dates back to the theorists most often cited as founders of constructivism: Vygotsky, Piaget, Dewey, Bruner." As we learn more about how the brain operates, the evidence supporting active learning opportunities makes the benefits of cooperative learning obvious.

Resources: Text

Kagan, Spencer (1994). *Kagan Cooperative Learning.* Kagan Cooperative Learning, 27134 Paseo Espada, Suite 302, San Juan Capistrano, CA 92675, 1994. 1(800) WEE CO-OP (800-933-2667). $29. *This is an extensive guide to CL based on Kagan's structural approach — structures are taught which can be used with varying content. The manual incorporates many of the ideas of other researchers and developers and includes an extensive bibliography. Kagan emphasizes the development of both academic and social skills. Extensive catalog available.*

Slavin, Robert E. (1995). ***Cooperative Learning: Theory, Research and Practice. 2nd Edition.*** **Allyn and Bacon, 160 Gould St., Needham Heights, MA 02194-2510.** *Focuses on what teachers need to know both about the theory and the practice of CL. Slavin is an award winning researcher and perhaps best presents the case for the effectiveness of CL.*

Cooperative Learning: The Magazine for Cooperation in Education. **IASCE, Box 1582, Santa Cruz, CA 955061-1582; 408-426-7926, $30.** *This journal, published by The International Association for the Study of Cooperation in Education (same address), generally covers the field, devotes special issues to topics from science to language arts to physical education, keeps readers informed about new developments, presents discussions on controversial issues and publishes an issue devoted to reviews of books and other resource materials every few years.*

For information on the **Johnson Brothers** approach to cooperative learning, contact **Interaction Book Company, 7208 Cornelia Drive, Edina, MN 55435; 612-831-9500.** *There is a catalog of materials available. The Johnson brothers emphasize role assignments in teams and the learning of social (interpersonal) skills.*

Internet Resources

- **Cooperative Learning Listserv**: In order to subscribe to the *listserv cl@jaring.my*. Send mail to: *<listserver@jaring.my>* with the following request: subscribe CL Your Name
- **Collaborative Learning: an Active Discussion**: *<http://forum.swarthmore.edu/discussions/co-learn/>*
- **Collaborative Learning:** *<http://ericae2.educ.cua.edu/k12assess>*
- **Using Portfolios in Educational Development**: Graham Gibbs (Open University) and Peter Seldin (Pace University) are putting together this web site. This page has a major section on CL: *<http://www.lgu.ac.uk/iem/>*
- **Getting Started with Cooperative Learning:** <http://www.crocker.com/~rebotis/profsubjects/cooperativegetting.html>

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Creativity in Children

A Handout for Parents

**By John C. Houtz, Ph.D.
and Carol D. Lewis, Ph.D.
Fordham University, New York, NY**

Background

Creativity is not just the province of a few very talented individuals — child prodigies or intellectual geniuses — although all societies and cultures have exemplars of such exceptionality. Creativity is not something mysterious, magical or otherwise unexplainable, even though many writers like to use such terms when describing some of civilization's greatest insights or productions.

On the contrary, creativity is something all of us experience and can learn to pursue. The scientific study of creativity and creative problem solving has been going on for many decades and quite a bit of useful and dependable knowledge has been accumulated. Given the growing complexity of our world, it is increasingly important that children, especially, learn about creativity. Every child can learn skills, attitudes and techniques that will help him or her think more creatively and work for more creative solutions to difficult problems.

The following are some suggestions for parents interested in developing or reinforcing their children's creative potentials, for stimulating as Schaefer (1973) has said "their children's individuality and unique self-expression."

Suggestions for Parents

Encourage novelty: Creativity involves making something new and different, something unusual, novel, surprising. The "thing" can be a painting, a poem, a proof to a mathematical theorem; it can be a new toy, a new tool, a new kind of shoe. It can be big or small; it can be real or theoretical; it can be an idea or an actual invention. With this in mind, parents can encourage creativity in their children by attending to their children's productions and pointing out and praising novelty or originality when it occurs.

Encourage effort: A creative product also has the qualities of usefulness, relevance, or appropriateness to the situation or problem. Originality alone is not sufficient. Children need feedback, especially from their parents, that is constructive to their thinking processes or their ideas or creations. Both effort and achievement can be rewarded. Children should be taught that errors are inevitable and that they should be valued as opportunities for new knowledge and growth, not viewed as failures.

Encourage imagination: Many writers and researchers have described the importance of children's imaginative play to cognitive development and, specifically, to creativity. In such play, children are, in effect, inventing concepts and relationships. Whether a child builds a fort out of cardboard boxes or dresses a doll for a grand ball, the positive effect on cognitive development is the same. Thus, children who experience greater stimulation and challenge, through so-called "enriched" environments, through adult encouragement and support, or through combinations of these influences, are building larger and deeper cognitive schema. They are, thus, increasing their chances for creativity or creative problem solving and maximizing their individual talents, whatever they might be.

Limit parental guidance: The type of parental support and guidance, however, is critical. Essentially, the more work the parent does, the less imagination from the child is required, the less will be the benefit to the child's own development. Parental guidance should be limited to those activities that adults *must* do rather than *can* do for their children, so that they do not inhibit their children's creative initiative or developing sense of independence.

Encourage problem solving: Parents, of course, can model good problem solving habits and skills for their children. They can encourage their children to consider alternative possibilities before making final decisions. Using day-to-day activities and relevant problems in their children's lives, parents can encourage even very young children to think carefully about problems, gather necessary information, make plans for courses of action, and analyze outcomes. A key element here is parents really permitting their children to make meaningful decisions and carry out their plans. Thus, children see that they can exercise control over the world through good thinking.

Model curiosity and wonder: Parents can take their children to new places, to libraries, zoos, museums, planetariums, gardens, offices, businesses, factories, etc. They can ask questions, engage in serious work, intellectual pursuits, read, do research, etc. They can show their children that they, too, value learning new things.

Encourage special interests: Parents can observe their children's interests and developing hobbies, habits, or pursuits. They can be attentive and responsive to children's particular likes and dislikes. They can encourage their children to pursue special interests and help them to find out about events or activities that they express interest in. They can join children in activities, offering guidance or simple companionship. They can help them meet other individuals with similar interests or good models (i.e., masters, mentors) who might help their children further develop their interests and skills. Look for areas where children's interests and skills overlap.

Encourage, don't push: Generally, the research suggests that preschool programs aimed at basic cognitive or social skills development are not injurious to children and that many children benefit from such experiences. Parents, certainly, may introduce mental puzzles and games to their children and play these games with them. However, parents should not force these or other activities on their children, lest they risk their children developing strong dislikes or avoidance behaviors. Such would defeat the purpose of such activities and preclude the development of children's creative motivation. If parents are concerned about "pushing" their children too far or too fast, they should talk with their children and discuss what their children's own thoughts and decisions might be.

Provide emotional support: In addition to thinking skills, creativity depends upon attitudes and emotions and personality characteristics. Developmental psychologists acknowledge that environmental influences play a major role in affective as well as cognitive and physical growth. Early experiences can establish styles and preferences, dispositions, and childrens' self-perceptions. Parents can support or otherwise encourage their children's enthusiasm for learning and solving problems and they can reinforce important characteristics of curiosity, independence, risk-taking, determination, and perseverance.

Encourage a sense of humor: Humor has long been associated to creativity in research studies. Parents can show enjoyment, amusement, and laughter. They can encourage their children to tell simple jokes, make up their own jokes and humorous stories, and explain new forms of humor as their children gain new experiences and increase their understanding of humor.

Support school experiences: Beyond the preschool years, parents can continue to take an interest in their children's school performance and their developing competence and interest in school subjects. Parents can work with school personnel to learn about their children's strengths and weaknesses and to develop appropriate educational programs for their children. If extracurricular, after-school, or Summer programs geared to their children's abilities or interests become available, parents can encourage their children to take part in them and support their efforts to make the most of these opportunities. If such programs do not exist in the school system or the nearby community, parents can try to find opportunities elsewhere or try to create such opportunities locally.

Encourage self confidence: Support from older children and/or adults is especially important when the child's creative efforts are rebuffed by others. New ideas often are ignored or viewed unfavorably by others. If this happens to creative children often, they may require support to help them understand that having good ideas does not guarantee that others will accept them. Nevertheless, creativity requires the self-confidence and determination to keep trying.

Resources

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Csikszentmihalyi, M., Rathunde, K., & Whalen, S. (1993). *Talented teenagers: The roots of success and failure.* New York: Cambridge University Press.

Khatena, J. (1978). *The creatively gifted child: Suggestions for parents and teachers.* New York: Vantage Press.

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Creativity and Education

A Handout for Teachers

By John C. Houtz, Ph.D.
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Background

Creativity is an important educational goal. Commentaries on the state of American education and calls for reform in schools and classroom practices point to the importance of creativity or creative thinking abilities. Surveys of civic and business leaders as well as educators and researchers yield the same conclusion — that, with the day-to-day pressures and complexities of modern life, our children need to develop their creative thinking and problem solving skills if they are going to be successful in their jobs, careers, homes and families.

We are not talking simply about providing for the few truly outstanding or exceptional individuals — so called "creative geniuses" — that come along once or twice in every generation (or even less often). The knowledge base that researchers have constructed about creativity and the educational practices that encourage the development of creative thinking are not restricted to a few special or "gifted" classes in every school or district. There is a great deal that can be applied to regular classroom instruction for all pupils that will enhance the growth of every child's creative attitudes and skills.

Underlying Principles

When speaking of creativity or creative thinking or creative problem solving, most writers are referring to cognitive thinking processes or skills that lead to the development of some new or novel idea, process or product that has usefulness or value. To be creative, an idea must be original as well as useful or appropriate. Without the judgment of value or worth, we might judge the concoctions of "evil scientists" or the hallucinations of psychotic patients as creative products. Without the judgment of originality, cleverness, unusualness, etc., we might have to declare creative the first sentences of a toddler or learning that "2+2=4."

Creativity has long been a subject of study by educators and psychologists and many theories have been advanced to try to account for the phenomenon. The behaviorists naturally focused their efforts on identifying external, environmental conditions that reward or reinforce creative expression. Freudian and neo-Freudian psychodynamic theorists have focused their efforts on identifying the personality characteristics and motivations that set the stage for and continue to push the individual to creativity. The original Gestalt psychologists and current cognitive psychologists focus our attention on the characteristics or contexts of the problems about which we must think and on the specific types of information processing skills that are used during problem solving. What has come from these varied theories and approaches is the principle that creativity is the result of a complex interaction of many factors — the social environment, the person and the nature of the problem.

Creativity requires knowledge — information about the problem at hand as well as useful, acceptable, appropriate ways to manipulate or transform that information. Consequently, children should learn facts as well as methods and processes when they study a domain. Modern learning theory suggests that expertise develops only over a long period of time, with extensive experience. Thus, before one can expect pupils to be creative in a field, they must acquire the basic knowledge of that domain and the skills typically employed to study it.

Creativity requires motivation to look for the different answer or the unanswered questions. Research shows that creativity and general intellectual ability are correlated, but it is not always the brightest students who are the most creative. Often, it is the smart but determined, independent-minded, somewhat "fearless" pupil who has the desire and the courage to pursue an intriguing problem until a new solution is formulated.

Characteristics: Creativity is associated with a distinctive pattern of personality characteristics and styles. Creative persons appear more independent, open to new experiences, interested in ideas, courageous, persistent and uninhibited. They also appear at times introverted, withdrawn, critical, unhappy, dissatisfied, stubborn and/or intolerant. Theory suggests that these apparently conflicting characteristics and moods of creative persons are essential. As creativity typically requires a "joining" of heretofore unrelated ideas, of "breaking sets" and traditional ways of doing things, of confronting and challenging the established order, creative persons must naturally exhibit a wide range of disparate behaviors to respond to the conflicting demands within both the problem and the environment.

Research on workplace and other social environments that support creative individuals and the creative process reveal characteristics such as freedom, adequate resources, flexibility, no pressure to conform, opportunities to try out new ideas and to consult freely with colleagues, adequate time, rewards for creative productivity, etc. It is the flexibility and "responsiveness" of such environments that permit the creative personality to function without repression.

Teaching for Creativity

Recommendations for teaching practices that will encourage the development of creativity, creative thinking, or creative problem solving include the following:

Encourage unusual, original thinking: Teachers should make clear statements that they want unusual, creative, original ideas and when they receive them, praise or otherwise reward them appropriately. Whenever possible, teachers should model creative action or behavior for pupils. Teachers can continually remind pupils of the diversity of creativity outcomes, such as fluency (many ideas), flexibility (different types of ideas), originality (rare or unusual ideas) and elaboration (detailed, fleshed-out ideas), and select activities and assignments that will call for these different outcomes.

Teach idea generation: Teachers can teach their pupils several traditional idea generation techniques, such as using brainstorming, idea checklists, bionics, attribute listing, morphological analysis, or the use of mental imagery. Teachers should demonstrate the use of these techniques and take the time to develop their pupils' skills with these techniques in a variety of situations or with different types of problems.

Encourage individual ideas and interests: Teachers should plan for and insure that pupils have a say in the types of topics or areas that they would like to study, and permit pupils to study topics in depth, which may culminate in some project or presentation. Gradually, but consistently, teachers should require, permit and encourage pupils to work independently on topics or ideas of special interest to them. Teachers should "mentor" students or develop a mentoring program to help pupils learn to work creatively with experts in a field.

Use objective and positive feedback: Teachers should withhold judgments and teach their pupils to reserve judgment so that negative feedback will not stifle ideas during the creative problem solving process. Teachers should not make overly critical, emotion-laden, disparaging comments. Instead, they can provide useful, "matter-of-fact" feedback when asked for by pupils. They should encourage pupils to make their own reasonable and informed evaluations at appropriate times during creative work. Teachers should try to remain optimistic and communicate positive attitudes and expectations about their pupils' abilities to generate ideas and solve problems.

Focus on efforts: Teachers can reward work in progress as well as final products, even if unfinished work has led to misdirections or errors, pointing out that motivation and effort can be as important as results. Look for the benefits to be garnered even from a failure experience. Then focus attention on next steps.

Encourage divergent thinking: Teachers can use mysteries, unanswered questions, conflicting ideas, conundrums, inconsistencies, etc., to heighten pupil interest and stimulate their thinking. Teachers should ask their pupils to make guesses, to hypothesize, to make estimates, or to look for causes and consequences of possible actions. Teachers should then provide for and encourage their pupils to conduct experiments and do their own research to test out their ideas and predictions.

Ask "why" questions and for explanations for answers, not simply the right answer. If this technique yields unsatisfactory responses, teachers should provide follow-up or follow-through activities to answer the questions and improve the responses.

Vary methods and media: Teachers should use a variety of different teaching methods over the course of one topic and different media for presenting information and interacting with pupils. For example, both cooperative and competitive goal structures and teaching techniques should be used. Aural, visual and other sense modalities should be employed when possible and appropriate to expand the range of pupil — information interactions and expressions. Teachers also can teach two or more subjects together, drawing connections between them, requiring pupils to notice interrelationships, similarities and differences, implications, etc.

Present role models: Teachers can have pupils study the lives of famous creative persons and their inventions or contributions.

Provide activities to encourage creativity: Teachers can employ a variety of published higher-level thinking skills programs and introduce creative, critical thinking, and problem solving puzzles or activities into the general curriculum, often as games or special activities as rewards for work on other parts of the curriculum. Teachers also can conduct "invention" exercises or use "creative writing" activities on a regular basis. Classes, schools and school districts also can join and participate in regional or national creative problem solving competitions, such as "Olympics of the Mind" or "Odyssey of the Mind".

Be alert to creative potential: Teachers can watch for pupils who display characteristics indicative of creativity, such as independence, curiosity, leadership, reflectiveness, sense of humor, assertiveness, productivity, etc., and try to provide a challenging-enough program to fully engage those pupils. By the same token, teachers should keep in mind that some characteristics with negative potentials (such as stubborness, opinionated, impatience, withdrawn) are equally part of the overall, integrated creative personality and should not be responded to negatively. The best response of a prepared teacher is to have established classroom rules, procedures and a diversity of opportunities and resources (an "elastic" classroom environment) so that the "negative" potentials can be exhibited in due course during creative work without harm and interference to others.

Resources

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Curriculum-Based Measurement

A Handout for Parents

by Andrea Canter, Ph.D., NCSP
and Doug Marston, Ph.D.
Minneapolis Public Schools

Overview

Curriculum-Based Measurement ("CBM") is a method of measuring student achievement developed at the University of Minnesota. Traditional tests typically measure a student's skills compared to others in the same grade, but CBM measures a student's ***progress*** in the same curriculum used in the classroom. CBM has a number of advantages over traditional achievement tests: 1) CBM is ***relevant*** to the student's instruction because it uses the very same materials as the classroom teacher; 2) CBM procedures are simple and can be used ***frequently***; 3) CBM is sensitive to small changes in student learning and therefore helps teachers track student progress over time; 4) unlike many traditional tests, CBM procedures are ***not culturally biased***; 5) CBM requires students to ***directly demonstrate their skills*** ; 6) CBM helps teachers determine ***if their instruction is effective*** or needs to be changed.

CBM does not refer to a specific test but to a ***process*** of gathering information about student achievement. In reading, for example, brief passages from the student's reading text are selected. The student reads passages aloud for a brief period of time (such as one to three minutes), and the number of words read correctly is recorded. Research has shown that ***words read correctly*** are highly related to ***reading comprehension and other reading skills***. Other CBM reading procedures include asking students to retell stories or answer questions about what they have read. To measure math achievement, CBM procedures include measuring the student's accuracy in performing addition, subtraction, multiplication, and other calculations. There are also CBM procedures to test spelling and writing skills.

CBM is not a substitute for traditional testing. Students should be tested using a variety of methods in order to obtain a complete picture of the student's skills and instructional needs. CBM was originally developed to help measure student progress but has also been found to be helpful in identifying students who might need special or remedial educational services. In some schools, CBM is used weekly by teachers in order to chart student progress and identify which students need some additional help. Research on CBM has found that these procedures provide consistent and useful information which can lead to improved instruction and, ultimately, to improved student achievement.

How Do Teachers Use CBM?

- **To measure/monitor student progress:** Teachers determine the "baseline" or "starting point" for students using CBM procedures, usually called "probes." Several different probes are used to determine the student's current level of skills. Then, at frequent intervals (such as weekly), the same probes are used and student performance is charted on a graph and trend toward improvement is studied. If the trend is generally in the desired direction (for example, increasing the number of words read or spelled correctly), the student is considered to be benefitting from instruction. However, if the trend shows no steady growth, then a change in instruction is warranted. This might mean using a peer tutor, changing the method of teaching, or using different materials. Frequent use of CBM allows teachers to make ***immediate*** changes rather than wait until the end-of- the-year tests or even end-of-textbook tests.

- **To help make programmatic decisions** about an individual, a group or class, or an entire school or district: By grouping CBM information, teachers and administrators can determine if the reading or math curriculum is generally effective or if more resources or different strategies are needed. If students in a particular reading group or classroom show little progress, this might suggest a need for a different type of teaching approach or perhaps a change of textbook.
- **To identify students who need special help:** Schools and even classrooms have developed "norms" using CBM procedures. They test everyone in the class or the school and then determine how typical students perform. By comparing an individual child to this "norm," staff can identify which students are having the most difficulty and might be in need of special services. For example, students falling in the bottom 20 per cent of second graders in correctly reading words (reading fluency) might be provided with special tutoring. Some students might be referred for comprehensive testing in reading to determine if they should be receiving special education or Chapter One services.
- **To involve students directly in measuring progress:** CBM procedures are simple to use and the results are easy to chart on graphs. Older students (upper elementary and secondary students) can easily learn to test each other with CBM probes and to make graphs of their progress. This helps to save teacher time but also helps students take responsibility for their learning. Making charts also helps students see their own progress.

How Can CBM Help Parents Help Their Children?

- **Keep track of your child's progress!** If your child's teacher uses CBM, ask to see the results as often as possible. Ask for copies of any charts of your child's progress in reading, math, spelling, or writing. Keep these posted in a highly visible area so that you and your child can watch progress together. If you notice that the chart indicates your child is not making much progress, ask for a conference with the teacher to discuss how you might help at home.
- **Practice academic skills at home.** In addition to any regular homework your child brings home, spend some time with your child each day practicing basic skills such as reading aloud, writing, and figuring out math problems. Since we know that increasing ***fluency*** (accurate reading rate) is related to overall reading skills, frequent opportunities to read aloud will help children become better readers. Parents and children can take turns reading stories and passages from interesting books or magazines. Children can practice writing skills by writing letters to friends and relatives.

What Questions Should I Ask My Child's Teachers About CBM Testing?

If your school uses CBM procedures, the following questions will be helpful to ask at your child's conferences:

- How often is progress measured using CBM?
- Exactly how is progress measured in reading, math, writing and spelling? (Ask teachers to describe each procedure so you understand what is required!)
- Do the results of CBM indicate that my child is making satisfactory progress? (Ask to see charts.)
- What changes have been made in my child's instruction to improve his/her learning? Should my child have some additional testing to help determine if different instruction is needed?
- What other types of achievement testing are used at school? What do the results of these tests mean for my child?
- What can I do at home to help my child?

Resources

Effective use of CBM procedures requires some training and practice. Most states and many districts offer workshops on developing and using CBM . Ask your child's teacher, the school psychologist, or special education director for more information about the use of CBM in your child's school. For in-depth information, the following textbook is recommended:

Shinn, Mark (Ed.)(1989). *Curriculum-Based Measurement: Assessing special children.* New York: Guilford Press. (In particular, see chapter by D. Marston.)

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Curriculum-Based Measurement

A Handout for Teachers

by Andrea Canter, Ph.D., NCSP, and
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Overview

Curriculum-Based Measurement is an alternative approach to assessing student achievement developed by Dr. Stanley Deno and Phyllis Mirkin at the University of Minnesota. CBM offers a data-based approach to making instructional decisions within both regular and special education. While traditional norm-referenced tests are typically lengthy measures of students' general achievement in comparison with the general population, CBM is a simple set of procedures for frequent and repeated measurement of student performance. CBM's advantages over traditional tests include 1) relevance to instruction by using the same materials used in the classroom, 2) focus on repeated measurement to monitor student progress (sensitivity to change in performance), 3) lack of ethnic bias, 4) utility in charting (graphing) student progress over time, 5) students' production of learned skills (actually reading, computing, or writing) rather than selection of a correct choice in multiple-choice or true-false formats and 6) feedback on the effectiveness of instructional interventions.

CBM does not refer to a specific test but to a process of gathering information about student achievement. In reading, for example, brief passages from the student's reading text are selected. The student reads passages aloud for a brief period of time (such as one to three minutes), and the number of words read correctly is recorded. Because research shows this procedure to be highly related to general reading skills, monitoring words read correctly in the reading curriculum is an efficient way to assess reading progress. Other CBM approaches that assess reading skills include retelling stories or responding to a series of questions about a reading passage. In math, computational skills are assessed and monitored by asking the student to perform calculations from instructional materials (such as a sheet of 20 addition or subtraction problems); the total number of correct digits or answers serves as the benchmark of student math progress. CBM has also been applied to the assessment of spelling and writing skills.

CBM is not intended to be a substitute for other types of assessment. Good assessment is multidimensional, collecting information from a variety of settings and using a variety of tools. While CBM was initially used to measure student progress, the development of local norms makes CBM useful for identifying students who need additional support. CBM has considerable relevance to the regular education classroom as well as to special education. In some schools, CBM procedures are used weekly with all students to monitor progress.

There has been considerable research regarding the use of CBM procedures. Generally, researchers have found that CBM measures are *reliable* — they yield consistent results; CBM is *valid* — it differentiates students with disabilities from those needing remedial instruction from those who are progressing well within regular education; CBM provides information which leads to *improved instruction* and improved educational *programs*. CBM has also had a positive impact on the role of educators: It has facilitated collaboration among regular and special education personnel; it has reduced assessment demands on psychologists who then have more time for intervention activities; it has provided regular education teachers with an efficient tool for measuring student growth and signalling a need to change instructional strategies.

How Can I Use CBM?

- **To measure/monitor student progress:** Once the assessment materials (often called "probes") are selected, baseline or "starting point" data are gathered for the student or for each student in the classroom. Because CBM probes are intentionally brief, it is important to collect several probes at each measurement point to be assured of reliable information. Once the baseline is obtained, the same CBM procedures are repeated at frequent intervals, such as once per week. Results are graphed and the general trend of the student's progress over time can be plotted in reference to an instructional goal.
- **To help make programmatic decisions** about an individual, a group or class, or an entire school .or district: By looking at group information, teachers and administrators can make decisions about the effectiveness of a particular curriculum or instructional approach. This information might be used to document the need for additional resources, a new textbook series, etc. By looking at individual student information, teachers can justify a change in instructional strategies, a change in IEP or classroom goals, or document mastery of specific material. If graphing demonstrates that the student is not making satisfactory progress, instruction can be adjusted immediately rather than waiting for a year-end test.
- **To identify students for special instructional support:** Establishing local norms for CBM probes allows educators to determine a student's need for special instruction relative to the local peer group. For example, students falling in the bottom 20% of the second grade group at School X might be designated to receive peer tutors, or to be referred for more comprehensive assessment to determine special education needs. In some districts, CBM procedures play a significant role in the special education assessment and decision-making process.
- **To involve students more directly in the assessment/monitoring process:** CBM procedures are easily administered and graphed. Older elementary and secondary students can graph their own progress and administer probes to their peers. This not only helps make more efficient use of teacher time, the process of repeated measurement and graphing is usually reinforcing to students and enables them to literally see their own progress.

Resources

Effective use of CBM procedures requires some training and practice. Most states and many districts offer workshops on developing and using CBM . The University of Oregon (Eugene) offers a summer institute of CBM workshops each year. Selected references include:

Deno, Stanley (1985). Curriculum-based measurement: The emerging alternative. *Exceptional Children, 52,* 219-232.

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Shinn, Mark (Ed.)(1989). *Curriculum-based measurement: Assessing special children.* New York: Guilford Press. (In particular, see chapter by D. Marston.)

For information about the summer CBM institutes at the University of Oregon, contact: Mark Shinn, Department of Educational and Counseling Psychology, College of Education, University of Oregon, Eugene, OR 97403

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Gifted Children with Special Needs

Suggestions for Parents, Teachers and Students

by Deborah Peek Crockett, Ph.D., NCSP
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Introduction

Traditionally, children were identified as gifted based on intellectual measurement. Recent definitions of giftedness focus on the concept of multiple intelligences and its associated characteristics. Multiple intelligences defines giftedness as the highest level of expression of any of the seven areas of intelligence: logical/mathematical, spatial, verbal/linguistic, interpersonal, intra personal, bodily/kinesthetic and musical. Other behaviors commonly associated with gifted students are listed below.

Parents, teachers, and students are reminded that when a student is both gifted and disabled, the presentation of the symptoms will be woven together and can be difficult to separate out for treatment. Depending on how services are delivered in the schools, the student may receive gifted and special education services concurrently. Careful evaluation of the student's needs and collaboration of all teachers is necessary so that the student does not become overwhelmed by the different programs. For some children, they should be included in the planning and monitoring of their schooling.

Characteristics of Giftedness

- Superior intellectual functioning, IQ's of 120 and above
- Large vocabulary, highly verbal, early language acquisition and usage
- Frequently asks "why" or "how" questions
- Likes to problem solve often with minimal assistance
- May combine two or more unrelated objects and/or concepts in a novel way
- Uses humor in innovative ways
- Accelerated moral development
- Development may be uneven — may be age appropriate in some areas, typically in physical development, but accelerated in others
- Often prefers to interact with older peers and/or adults rather than with own age group
- Is persistent in pursuit of interests
- Understands principles and concepts quickly
- Produces several ideas from a specific stimulus
- Is critical of himself and others
- Tends to be more independent and does not like structure

Identification

When a student has a disability, determining potential becomes more difficult. Consequently, traditional methods for assessment do not always reveal the accelerated skills of these individuals. As a result, their "gifts" may require additional and/or alternative methods for identification and service. Gifted disabled students can be difficult to identify because school personnel may focus on behaviors consistent with categories of the Individuals with Disabilities Education Act (IDEA) only and not look further for characteristics of giftedness. In order to achieve a more comprehensive picture of these students, a full array of assessment procedures needs to be used for detecting subtle signs of superior potential and ability.

- Group administered tests unless the disability is language and/or attentionally based. These tests may be used with alternative instructions and/or accommodations for the student's disability. Analysis of the student's performance maybe more appropriate than relying on scores.
- Individually administered tests, including intelligence, achievement and creativity tests with accommodations as needed by the presenting disability, e.g., non-speeded items, large print, nonverbal items, use of computer for output.
- Student portfolio, work samples, student journals and other student records.
- Systematic observation of the student, anecdotal records, video and audio tapes.
- Checklists completed by several people including but not limited to teachers, parents, administrators, the student and any individuals knowledgeable about the student.
- Student products such as science fair projects, art work, poems and essays, oratorical contests, dance recitals, etc.
- Structured interviews, oral and written.
- Student and self nominations and sociograms.

Gifted Students with Learning Disabilities

Gifted students with learning disabilities have received the most attention in the research literature. Most of these students display characteristics consistent with the disability definition. Additionally, researchers have reported both verbal and performance discrepancies and behaviors consistent with Attention Deficit Hyperactivity Disorder. The following recommendations may be used with any student with learning problems. However, for gifted students the key is to, as often as possible, allow the student to guide the remediation process. The student may be unable to complete simple tasks but can successfully perform more complex tasks. Variation in the order of instruction presentation may be necessary to help these students be successful. Other suggestions follow.

Adjustments For Learning Problems

- Computers, calculators, tape recorders
- Tutorial software
- Self-help books, self-guided tours, how-to-books, self-paced instructional materials
- Charts, diagrams, graphs
- Open-ended journals
- Personal guides to "walk" students through material to be learned. This includes tutors and study partners.
- Art therapy, movies and books with interpersonal themes
- While expectations for the student are high, monitor the student's functioning to assure that he does not require periodic academic adjustments as an academic stress reducer.
- The gifted student may have great ideas, but poor planning, execution, and evaluation abilities. Teach the student how to plan and organize his work. Provide guidance as to how to self-evaluate completed work. Be aware that once the learning obstacle has been cleared, she may push your effort to assist her aside. Monitor her progress for acceptable work. Offer assistance when assignments reflect a need for further instruction.

Gifted Students with Behavior and Emotional Difficulties

Gifted students present the same acting out behaviors, adjustment difficulties and emotional distress as any other individual. In fact, dependent on the age of the child, perfectionism, conformity and competitiveness can result in behaviors that lead to placement in special education. Academic functioning may remain at an average to high level for these students, resulting in a need to address their emotional functioning only. For these students, understanding their personal needs is essential to developing an appropriate plan for addressing these difficulties.

Adjustments For Emotional/Behavioral Problems

- Seek counseling services for the student from the school psychologist and/or other pupil personnel staff. Assist the student by explaining what gifted is, the implications for her education, and ways for the student to access support when she feels a need to talk to someone.
- Provide guidance for the student who fails to engage in work because of perfectionistic behavior or fear of failure.
- Identify an older student or adult for support and to serve as a role model for the student.
- The gifted student may have detailed insight into his feelings but will need some direction and assistance from professionals in how to cope with these feelings.
- Teach the gifted student coping and problem solving skills. The literature suggests that these students are able to select and monitor their behaviors based on social skills strategies they have learned.
- Gifted students may not have an adequate self-image. Because some tasks are easy for gifted students, they may not understand the uniqueness of their performance. Give the students ongoing realistic feedback about their performance.
- If the student is unwilling to take academic and social risks, make sure the student has the skills necessary to perform the task before pushing him/her to do it.
- Allow the student to experience success by solving problems that give him immediate feedback about his performance.
- Have the student use self-reward for *attempts* at success as well as for achieving success.
- Teach the student stress reduction techniques such as "Stop and Think" exercises.
- Teach the student compliance behaviors such as "Sure I Will".
- Assist the student in developing clear understanding of his personal strengths and weaknesses.
- Review resources that address ADHD interventions.

Gifted Minority Populations

Minority and limited English proficient students are frequently overlooked for gifted services. Compounded by special education disabilities, the disabled-gifted student may not be considered for gifted services in addition to other remediation services. The recommendations listed above are suggested along with the following modifications:

- Evaluate signs of superior functioning in non-school activities such as in recreation, civic, religious and other social settings.
- Use direct instruction to increase knowledge acquisition, recall and retention.
- Use culturally relevant materials and experiences.
- Use more activity, color and interpersonal interaction for academic tasks.
- Acquaint parents and teachers with community resources designed to enhance student performance.
- Provide sessions for parents and students to explain gifted and special education disabilities, educational services for both programs, and the implications of both categories.

Resources

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Children's Resources

Challenge, P.O. Box 55682, Boulder, CO 80323-5682.

Child Life, P.O. Box 567B, Indianapolis, IN 46206.

Cricket, Cricket League, Box 100, LaSalle, Il 61301.

Ebony, Jr!, 820 S. Michigan Ave., Chicago Il 60605.

Gifted Children Monthly, P.O. Box 115, Sewell, NJ 08080.

Highlights for Children, 803 Church St., Honesdale, PA 18431.

Sesame Street Magazine, Art Editor, Children's Television Workshop, 1 Lincoln Plaza, New York, NY 10023.

The Weewish Tree, American Indian Historical Society, 1451 Masonic Ave., San Francisco, CA 94117.

Websites

Academically Gifted Education, URL:< http://etrc33.usl.edu/coledu/degprog/coe/gr-progs/ac-gifted>

Gifted and Talented Instruction Resources, URL: <http://www.ops.gifted/gt.pro.html>

Gifted Child Society, URL: <http://www.gifted.org/>

Gifted Children, URL: <http://www.exxnet.com/gifted.htm>

Links for Parents of Gifted Children, URL: <http://www.mindspring.com/~mensa/pages/list7.htm>

School Programs for Gifted Children, URL: <htttp://nthsrv1.jsr.cc.va.us/courses/eng217/d/gifted_children>

Yahoo! — Education: K-12: Gifted Youth, URL: <http://www.yahoo.com.text/education/k_12/Gifted_Youth>

Organizations

Council for Exceptional Children, Gifted and Talented Division: 1-888-CEC-SPED (Headquarters)

National Association for Gifted Children (NAGC): 202-785-4268

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Inclusion of Students with Disabilities

A Handout for Teachers

by Anne M. Beninghof
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Introduction

Across the country, students with disabilities are entering regular education classrooms. Referred to by many as "inclusion," this movement of children brings with it great advantages and challenges. In response, educators across the disciplines are quickly trying to upgrade their knowledge base and skills in order to experience success with these students.

One of the greatest frustrations when talking or writing about inclusion is the proliferation of jargon used to describe it, including mainstreaming, integration, least restrictive environment and inclusion. The most contemporary term, "inclusion," was originally used by advocates to indicate that all children, no matter how significant their disabilities, would be included in general education environments fulltime. Recently, however, this term has been used in a more flexible manner to refer to a huge variety of experiences in which students with and without disabilities are brought together for valuable learning activities.

The benefits of inclusion, when done well, are many. Students with and without disabilities develop a variety of relationships, a greater acceptance of diversity and greater preparation for "real" life. Students with disabilities benefit from appropriate peer role models, high expectations of general education classrooms and greater chances to be independent. In addition, teachers of inclusive classrooms often report that the instructional modifications made for "identified" students often provide enormous assistance to other students in the classroom.

Underlying Principles

Recently, the Council for Exceptional Children released its list of 12 Principles for Successful Inclusive Schools (1994). These include vision, leadership, high standards, sense of community, array of services, flexible learning environments, research-based strategies, collaboration and cooperation, changing roles and responsibilities, new forms of accountability, access and partnership with parents.

At the classroom level, the following principles are most important:

Partial Participation — Partial participation means that a child can benefit from participating in an activity, even if she or he can not participate to the same extent as other children. For example, in a math lesson on multiplication facts, one student may partially participate by adding the numbers instead of multiplying, while another may work on number identification. It is up to the educational team to determine ways in which the child can participate and still receive educational benefit.

Normalization — The philosophy of normalization implies that children with disabilities should have made available to them experiences and opportunities that are as close as possible to those that typical children are given. One way this translates in classrooms is for adults to treat students with disabilities age-appropriately to the greatest extent possible, i.e., using an age-appropriate tone of voice when speaking with students, even if the student has developmental delays.

Interdependence — Goals for students with disabilities have traditionally focused upon their need to become independent. In inclusive classrooms, there is a recognition of the fourth "R" — reading, 'riting, 'rithmetic and *relationships*. Students are encouraged to utilize their peers for help at appropriate times, rather than develop an overdependence on adults in the classroom.

Individuality — Last, but not least, is the principle of individuality. If we are truly interested in providing the best education for each individual student, then inclusion must be individualized. What may work well for one child may not work as well for another child. Educational teams must continue to pursue the best educational methods and strategies for each individual child.

Inclusion Through Modification

Once students with disabilities are in general education classrooms, the main question teachers ask is "How do I modify to make this meaningful to diverse levels?" Good teachers have always practiced instructional and curriculum modification for students with special needs, often without labeling it as such. As more students are needing these adaptations, it may be helpful to consider modification as a step-by-step process (Beninghof & Singer, 1995):

Step 1 : Identify the Students' Learning Style and Strengths

The first step in modifying is to gather information about the student regarding his or her learning style and areas of strength. Without this information it is almost impossible to adapt instruction accurately. How can a teacher know whether the use of an overhead projector will help or hinder? Or, how effective books on audiotape will be? While these modification ideas may help some students, they may be a waste of time with others. Therefore it is essential to know if the child's dominant learning style is visual, auditory, tactile or kinesthetic.

Step 2: Analyze the Classroom Environment

Every classroom is different and should be assessed for its impact on learning. While we can't all have "state-of-the-art" facilities, there may be simple ways to adjust environmental variables — seating, lighting, noise, floor covering, wall hangings, etc. Ideas such as the use of "itty-bitty" book lights, various chair heights and seating students away from high traffic areas can make a world of difference to learning.

Step 3: Compare IEP Objectives with Lesson and Merge Where Appropriate

By examining the components of the lesson and the student's Individual Education Plan objectives concurrently, it is possible to determine which objectives should be focused on during which lessons. This is usually accomplished through the use of a planning matrix (Beninghof, 1994), on which a student's IEP objectives and class activities are listed and appropriate intersections are noted. This insures that the team is clear about which two or three objectives have been chosen as priority instructional needs for each period.

Step 4: Adapt the Lesson

Adaptations can take place in a variety of realms. Following are the most common areas for adaptation and a few of the best practices in each:

- **Instructional Style** — Many teachers use learning styles information during their lesson planning, so that they increase the use of tactile and kinesthetic activities in their teaching. Teachers also find that by increasing the use of projects and group activities, their classrooms become less teacher-directed and more student-directed. Finally, inclusive classrooms are usually more successful if staff provide a higher level of feedback and reinforcement to all students.
- **Content** — Often a student can show mastery of a concept with a shorter assignment. Sometimes, however, teachers may need to adjust the amount of work required, or adjust the vocabulary at which the work is presented. At other times it is necessary for the instructional team to prioritize the content for a student and choose the main concepts, rather than attempting to master it all.

- **Evaluation** — Some of the best practices in this area include having a district policy (in writing) that permits modified grading, collaboration in grading between special and general education personnel, and report cards that include both teachers' names. In addition, specific details about grading practices should be included in each year's IEP so that all parties involved are clear about evaluation agreements.
- **Level of Assistance** — Assistance can come in many forms. The most successful methods include peer tutoring, peer buddies, cooperative groups, cross-age peer tutoring, the use of paraeducators and collaborative teaching between general and special education and related services personnel.
- **Environment** — Many adaptations can be made to the environment without great expense. For example, covering a student's work surface with black or neon construction paper may draw his attention to his work papers. Establishing standing work stations in each room for students to stand at while they work often eliminates inappropriate behavior. Checking and adjusting for the level of glare on the chalkboard can also eliminate much frustration and failure for students.
- **Materials** — With the increasing access to technology, modification of materials is becoming more effective and efficient. Schools are beginning to use scanners to scan material into computers for editing, enlarging, adding graphics and white space, etc. For schools without this technology, modifications can include using Velcro and puff paint for tactile input, using cardboard masks to cover distractions, and pre-highlighting texts with color highlighters to identify main points the teacher will emphasize.

Inclusion can work successfully for students with and without disabilities! By following the underlying principles for success and a step-by-step process for modification, schools around the country are increasing their comfort and confidence with inclusion.

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Kindergarten Programs: Full Versus Half-Day

A Brief History and Research Synopsis

**by Jennifer Emery, Chrishelle Piche
and Christina Rokavec, Indiana University of Pennsylvania**

In 1837, a German philosopher and teacher named Friedreich Froebel founded the first kindergarten in Blankenburg, Germany. Rejecting the idea of strict discipline for young children, he sought to make children's initial experience child centered and physically active. Froebel's ideas about kindergarten came to the United States with the German immigrants. The first English speaking kindergarten was founded in Boston, MA in 1860 by Elizabeth Peabody. In the late nineteenth century the United States saw a rapid growth in the number of kindergartens. In 1884, the National Education Association (NEA) established a department of kindergarten and in 1891 Michigan became the first state to pass legislation to authorize the establishment of kindergartens. Rapid growth of kindergartens occurred after World War I. In order to accommodate more children and save money, most of the public schools initially ran half-day, double sessions of kindergarten (Bickers, 1989).

While during the Depression many kindergarten programs were cut, after World War II, the baby boom generation made half-day, double sessions of kindergarten again essential. A 1961 survey, completed by NEA, found that 90% of schools had half-day, double sessions and 3.5% had a full day session of kindergarten (Bickers, 1989). By 1989, 40-45% of all five-year-olds in the United States were enrolled in an extended day program(Olsen & Zigler, 1989).

The enrollments in extended day kindergartens have since continued to rise. The growing enrollment in extended day programs is due to the continuing changes in family patterns, including an increase in the number of both parents working (Rothenberg, 1984). The number of mothers who work outside of the home and have children under the age of six increased by 34% between 1970 and 1980, and is still on the rise(Grant & Snyder, 1983, as cited in Rothenberg, 1984). Additionally, a change in family patterns occurred, resulting in an increased number of children with preschool and day care experience. These experiences, rather than kindergarten, now provide many children with their first opportunities to engage in organized instructional and social activities (Herman, 1984, as cited in Rothenberg, 1984; Olsen & Zigler, 1989). Other changes include the influence of television and family mobility on children. Today, 5-year-olds know more about the world than ever before, which makes them more ready for a full-day kindergarten (Olsen & Zigler, 1989; Rothenberg, 1984). An increased number of single parent families also means that more children may need the enriched environment that a full-day kindergarten can provide. Finally, a renewed interest in academic preparation for later school success has created a demand for more early academic programs (Rothenberg, 1984).

Thus, full-day kindergartens may appear to have many advantages to school districts and to parents, but to be effective, they must be developmentally appropriate. Carmody (1992) writing in the *New York Times* quotes experts who argue that full-day kindergarten is most beneficial when the curriculum is developmentally appropriate. "...it (full-day kindergarten) can be twice as bad if the purpose is to cram more curriculum into the day to teach 5-year-old children material that should wait until first grade" (Carmody, 1992). Many states are now developing guidelines for children ages six and younger, based on the National Association for the Education of Young Children's (NAEYC) list of developmentally appropriate practices (Caldwell, 1989). According to Karweit (1992), the major challenge facing kindergarten is to provide developmentally and individually appropriate learning environments for all kindergarten children. Because children entering kindergarten vary in maturity, teachers need to try to draw several lessons out of one experience. For example, a trip to the store can provide a language experience, a math lesson and a science lesson. The language experience is making a grocery list, the math lesson is measuring the ingredients that the children bought, and the science lesson is a discussion on what happens when the ingredients are mixed and baked (Carmody, 1992). Teachers also need to "integrate meaningful subject matter, focus on experiential learning and higher order thinking, balance between child and teacher-initiated activities, recognize the importance of play, and view themselves as facilitators of learning" (Karweit, 1992, p. 84). On the other hand, some argue that half-day kindergarten can provide a high quality educational and social experience. Others feel that children's attention spans and interest levels are more suited to a half-day program (Finkelstein, 1983; Rothenberg, 1984). Table 1 contains a summary of current research on the efficacy of full-day programs.

Table 1
Research Summary: Full Versus Half-Day Kindergarten Programming

Research on Effects of Full Day Programs on Achievement	**Research on Effects of Full Day Programs with Educationally Disadvantaged and Low SES Children**	**Research on Other Effects of Full versus Half Day Programs**
Full day programs increased long term achievement (Humphrey, 1983, as cited in Rothenberg, 1984; McConnel & Tesch, 1986, Stinard, 1982, as cited in Rothenberg, 1984; Cryan, Sheehan, Weichel, & Bandy-Hedden,1992)	Full day programs allow for greater opportunity for assessment and screening (Herman, 1984, as cited in Rothenburg, 1984) reducing the long-term costs for special and remedial education (Housden & Kam, 1992)	Full day programs have been shown to raise children's self-esteem, independence, and creativity (Bickers, 1989; Cryan, Seehan, Weichel, & Bandy-Hedden, 1992) No evidence that the curriculum is more individualized or innovative (Finkelstein, 1983; Jarvis & Molnar, 1986 as cited in Olsen & Zigler)
Full day programs produce higher reading scores in second and third grade (Humphrey, 1983 as cited in Olsen & Zigler, 1989)	Full day programs show higher academic and social gains (Housden & Kam, 1992; Jarvis & Molnar, 1985 as cited in Olsen & Zigler ; Lysiak & Evans, 1976, Winter & Klein, 1970 as cited in Olsen & Zigler)	Parental involvement diminshed in Full Day programs (Olsen & Zigler, 1989)
Fewer grade retentions, higher report card marks, higher scores on standardized tests (Bickers, 1989 - meta-analysis of 30 studies)	Full day programs allow for more informal and formal instructional time on individual basis (Housden & Kam, 1992)	Full day is not found to cause excessive fatigue or stress in children (Evans & Marken, 1984, Stinard, 1982, cited in Rothenberg, 1984)
Full day provides more time for individualized instruction, academics, and the reinforcement of children's positive behaviors (Bickers 1989; Cryan, Seehan, Wiechel, & Bandy-Hedden, 1992, Housden & Kam, 1992)	Full day provides access to nutritional lunch as well as breakfast (Bickers, 1989)	Full day allows for unhurried, relaxed school day with more variety of experience (Herman, 1984, as cited in Rothenberg, 1984)
Full day programs found to have no effect on achievement (Evans & Marken, 1983)	Title I children have signifcantly higher achievement in Full day programs (Carpella & Loveridge, 1978, Cleminshaw & Guidubaldi, 1979; Mueller, 1977 as cited in Olsen & Zigler, Neiman & Gastright, 1981)	Children in full day programs have been shown to be less likely to be dependent, shy and withdrawn (Cryan, Sheehan, Wiechel, & Bandy-Hedden, 1992), Half day programs spent more time in large groups than in free play (Cryan et al, 1992)

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Learning Disabled Students

General Classroom Strategies

by Kristy L. Mayernick and Megan K. Werner
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Background

According to a 1994 report by the U. S. Department of Education, 10% of all children are classified as Learning Disabled. With the recent inclusion movement, more than 78% of students with learning disabilities spend the majority of their day in general education classrooms.

The increased presence of students with learning disabilities reinforces the importance of regular education teachers as primary facilitators of individualized learning in the classroom. In order to deal with children with various learning disabilities, it is critical that regular education teachers incorporate a positive outlook regarding the inclusion and potential learning *abilities* of all students.

Federal Classification Criteria of LD

Academic Component, Qualified by Discrepancy Factor:

1. *A team may determine that a child has a specific learning disability if:*
    A. The child does not achieve a commensurate with his or her age and ability levels in one or more of the following areas when provided with learning experiences appropriate for the child's age and ability levels: oral expression, listening comprehension, written expression, basic reading skill, reading comprehension, mathematics calculation, or mathematics reasoning.

    B. The team finds that a child has a severe discrepancy between achievement and intellectual ability in one or more of the same areas listed in the preceding statement.

Exclusion Component

2. *The team may not identify a child as having a specific learning disability if the severe discrepancy between achievement and ability is primarily the result of:*
    A. A visual, hearing, or motor handicap
    B. Mental retardation
    C. Emotional disturbance
    D. Environmental, cultural, or economic disadvantage

Characteristics of LD

Although every child with learning disabilities is unique, there are some characteristics that prevail. Primary characteristics include academic and language difficulties. Metacognitive deficits, social skills deficits, attention disorders, memory problems and motor problems are other common distinguishing features of children with learning disabilities. With an awareness of these characteristics, regular education teachers can improve the quality of their instruction and modify their methods for teaching children with diverse abilities.

Effective Teaching Strategies

Due to various learning styles difficulties of children in the general education classroom, individualized instructional techniques are necessary for students with a need for concrete and direct learning. Techniques that include *student involvement* in defining clear goals, monitoring progress of their goals and evaluating their performance are useful in increasing self-motivating behaviors. The result will be students capable of creating their own learning opportunities and at the same time feeling success in the classroom. *Metacognitive training* can help students discover more about how they think and learn individually and become more assertive learners, aware of their unique abilities. Practices that teachers can incorporate into their instruction that serve to help students with learning difficulties:

1. **Provide a daily review of what is taught each day.**
2. **Present new material in small steps.** This prevents students from feeling overwhelmed by large pieces of unfamiliar information.
3. **Provide guided practice.** This allows the students to rehearse and reinforce what was taught.
4. **Teach learning strategies.** Students with learning difficulties may need more structure in academic instruction. Basic academic skills may have to be re taught as a stepping stone to advanced learning. Children with learning difficulties need frequent positive feedback.
5. **Allow students to listen to books on tapes.** This gives students the opportunity to learn material visually and auditorily, and reinforces information input.
6. **Create handouts for students with learning disabilities.** Since it is often the case that students experience difficulties concentrating on what the teacher is saying and taking notes simultaneously, the use of handouts would give students the chance to visually process auditory information.
7. **Discuss planned questions with the individual student ahead of time**. This pre-teaching will help students focus on important information from discussion. It will also reduce the students' anxiety and help them have an equal opportunity to succeed in our educational system.

Resources for Teachers

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The Learning Disabled Child in the Whole Language Classroom

A Handout for Teachers

by Diane Schowalter
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Background

Ongoing reform in the field of reading instruction in the United States has resulted in widespread adoption of a Whole Language approach to literacy in the elementary schools. The Whole Language perspective views reading, writing, oral language and critical thinking as integrally related skills which function simultaneously in order to construct meaning and acquire language. Unlike a more traditional approach to reading that is based on basal readers and direct instruction emphasizing word recognition or phonics, Whole Language uses "real" children's literature with an emphasis on comprehension and authentic student responses.

While a pure Whole Language approach does incorporate the learning of phonics (sound/symbol relationships), phonics typically is not taught directly as a specific skill. Current research suggests that young students with phonologically-based learning disabilities do not acquire the sound/symbol relationships naturally and require more intensive direct instruction in the mechanics of both word attack skills and spelling. With frequent assessment of learning and individualized complementary instruction when appropriate, students with learning disabilities have the potential to thrive in environments that emphasize meaning and connected learning. In fact, many of the basic Whole Language experiences, such as shared reading and journal writing, are frequently recommended as part of comprehensive remedial programs for students with learning disabilities. In many respects, the Whole Language perspective is a refreshing change from the deficit model that is frequently applied in teaching students with learning differences.

Teaching Strategies for Students With Reading Disabilities

1. ***Use the child's own language:*** One whole language maxim is that a child's own language can become his or her beginning reading material. This technique may begin with a language experience approach whereby a student dictates a story to the teacher, who acts as a scribe. After a draft has been completed, the child may practice reading the story orally to develop word recognition and fluency skills. A variation involves writing one sentence from the story on a strip of paper and cutting the words apart so that the child can attempt to put the words in proper sequence.

2. ***Teach phonics generalizations*** by using words that are familiar to the child such as his or her name. For instance, when teaching "Jan" the short vowel sound for "a", she could be asked to compare other word sounds such as "that" with "Jan".

3. ***A variation on shared oral reading*** can assist in developing fluency for struggling readers. A passage should be chosen that is at or above the child's instructional level. First, the teacher reads the passage orally alone. The child joins in on the second reading, while the teacher maintains a fluent pace. Finally, the child reads the passage orally alone. This type of fluency practice provides children with greater confidence in their ability to enjoy the reading process.

4. ***Use taped literature:*** The Whole Language emphasis on meaning may be positively reinforced by having taped literature available to both learning disabled and non learning disabled students. It is

important to remember that the comprehension levels of many L.D. students are well above their actual independent reading levels. It is also useful to pair tapes with the actual trade books so that students can practice reading along with tapes on their own. Parents, community volunteers and even older students may be willing to tape books for your classroom.

5. ***Allow time for silent reading in the classroom.*** This is an opportunity to reinforce the importance of comprehension and independent reading. In order to encourage self-monitoring, students may be asked to write down any words that they don't know and emphasize strategies for figuring out unknown words. Individually or as a group, students may be asked to share ideas such as continuing to read and then coming back to the word, thinking about what word would make sense, substituting a word that does make sense, decoding the word phonetically, or skipping the word to go on. Finally, this collaborative list may be posted in the classroom or at each child's desk.

Teaching Strategies for Children With Written Language Disabilities

1. ***Emphasize the phonetic connections between reading and spelling*** by providing students with vowel and consonant cards that may be arranged to form words. For young students, the combinations should be as simple as "_an" and the children should be encouraged to think about word families which correspond to the patterns. Eventually, word games like "Boggle" and "Hangman" will also provide good practice.
2. ***Use direct instruction:*** Children who seem to benefit from rule-based learning, such as in math computations, may benefit from direct instruction in some basic spelling rules such as the "-ing" rule or the "silent e" rule. They may not be able to simply generalize and these basic rules can facilitate the transition from inventive to conventional spelling.
3. ***Use a "scribe":*** If a child is having difficulty with writing due to weak spelling skills or mechanical challenges such as fine motor delays or visual/perceptual concerns, having a scribe for various creative writing tasks will encourage him or her to continue to be excited about written language while working on emerging skills.
4. ***Hand-held electronic spellers*** can reinforce the connections between inventive and conventional spelling for older children. For learning disabled writers, these can be extremely useful in the editing process.
5. ***Monitoring checklists:*** Students with disabilities in written language may benefit from using an individualized monitoring checklist when editing their work. The lists should contain only a few items at first, such as capitalizing the first word in the sentence, capitalizing proper nouns and using punctuation at the end of each sentence. Once the initial items become fairly automatic, more items may be added to the lists.

Extending Learning to the Home Environment

While all students benefit from home/school collaboration with respect to learning, students with learning disabilities need the consistency and practice provided by reading and writing experiences at home. It is vitally important for parents to understand the theory and practice of Whole Language instruction so that they do not, inadvertently, contradict the support the child is getting in the classroom. For instance, parents need to understand the value and method of inventive vs. conventional spelling and the emphasis on process writing and editing vs. a single draft. One way this can be accomplished is by meeting with parents at the beginning of the school year and providing examples of work samples that demonstrate the Whole Language techniques. Teachers may also provide recommendations for parents such as the following:

1. ***Children should have a minimum of 20-30 minutes of daily reading.*** For children with reading disabilities, it makes sense to divide the time into silent reading that is done independently by the child (potentially with the use of taped books) and shared reading that is done with a parent and can be at a higher difficulty level.
2. ***Daily opportunities to write*** are also invaluable. Many children enjoy dialogue journals whereby they communicate back and forth with a parent or sibling on a regular basis. Children should be encouraged to write about special activities or vacations. If a personal computer is available, the child may be encouraged to experiment with creating books complete with illustrations.
3. ***Software:*** There is a great deal of good educational software on the market which encourages children to read text in order to solve problems and play games. These are wonderful incentives for children with reading disabilities.

Resources

Adams, M.J. (1990). *Beginning to read: Thinking and learning about print.* Cambridge, MA: MIT Press.

Mills, H., O'Keefe, T., & Stephens, D. (1992). *Looking closely: Exploring the role of phonics in the whole language classroom.* Urbana, IL: National Council of Teachers of English.

Routman, R. (1991). *Invitations: Changing as teachers and learners K-12.* Portsmouth, NH: Heinemann.

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Math Computation Skills

Cognitive Strategies for Teachers

by Jack A. Naglieri, Ph.D.
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Background

Many children lack both the knowledge of arithmetic facts and the problem solving skills that are important to be successful in Math (Das, Naglieri & Kirby, 1994). While direct instruction techniques to teach skills needed to be successful in math computation are important, children who perform poorly may also do so because they do not apply appropriate or effective methods when problem solving. When children are weak in the basic mathematics skills, the teacher is well advised to carefully evaluate the strengths and needs of the child and provide the needed instruction. When children perform poorly in math calculation because of poor organization, inadequate reflection on the procedures used, difficulty analyzing the demands of the problem, and failure to carefully monitor the work, then cognitive strategy instruction is necessary (Scheid, 1993).

Kirby and Williams (1991) have suggested that children who experience learning problems in mathematics computation may have a weakness in a cognitive process called Planning. This cognitive process is responsible for organization, reflection on the procedures needed, analysis of the demands of the problem, and monitoring work. According to Naglieri and Das (1997), Planning is one of the four basic cognitive functions of intelligence, and more importantly, this process can have important implications for intervention, for example, with children whose math calculation is poor.

There has been research that shows that children improve in math calculation when given cognitive strategy instruction. For example, Naglieri and Gottling (1997) found that children who are poor in planning improved 80% over baseline on classroom math computation assignments. Children who were average in planning improved about 40% over initial levels. This indicates that those who are low in planning especially need to have cognitive strategy instruction followed by more math instruction, but that all children improve when given the cognitive strategy instruction intervention.

Method

The Instructional Format

Teachers should conduct sessions in half hour group exercises consisting of three steps as follows: Step 1: 10 minutes of math; Step 2: 10 minutes of discussion; Step 3: 10 minutes of math. The teacher gives math assignments and says "Here is a math worksheet for you to do. Please try to get as many of the problems correct as you can. You will have 10 minutes." If a baseline period is used to establish initial levels of performance, the discussion should be unrelated to the math work. During intervention the group interaction is designed to encourage children to explain how they did the math. The following instructions are suggested.

The Intervention Format

After the children complete the math worksheet, the teacher facilitates a discussion which is designed to encourage the children to consider how they completed the work and how they will go about completing the pages in the future. Teachers do not attempt to reinforce the children. For example, if a child says "I used xyz strategy" the teacher should not say "Good, and be sure to do that next time." Instead, the teacher may probe, saying "and did that work for you?" or some statement designed to encourage the child to consider the effectiveness of the strategy. The teacher should encourage the children to:

- Describe how they did the worksheet
- Verbalize their ideas and methods (this facilitates planning)
- Explain why some methods work better
- Consider their own math knowledge needs
- To be self-reflective and self-evaluative
- To think about what they will do the next time they get the worksheet

Suggested Probes

- How did you do the page?
- Tell me how you did these?
- What is a good way to do these problems?
- Why did you do it that way?
- Did it work as you expected?
- What did this teach you?
- How are you going to complete the page next time?
- What seemed to work well for you before?
- What do you want to do next time?
- What are some reasons why people makes mistakes on problems like these?
- You say these are hard, can you think of any ways to make them easier?
- You say there are many problems here, can you figure out a way to do more?
- Do think you will do anything differently next time?

Aids to Facilitate Discussion

- Make an overhead of a blank worksheet so the children can see it during discussion
- Make an overhead of a completed worksheet (with the name omitted)
- Do a blank worksheet as a group on an overhead

What Teachers Should Not Do

The teacher's task is to facilitate not instruct, which means that the following statements should be avoided: Watch me, this is how to do it; That's right, good, now your getting it! You made a mistake, fix it now; Remember to use your favorite strategy. In summary do not give direct instruction, but rather bring the child to the point of recognizing the importance of strategies.

Summary

The cognitive strategy instruction technique described here has been tested in several experiments and shown to have value. The effectiveness of the method, however, may depend on many variables and the teacher and school psychologists should consider working together to monitor the progress of children and effectiveness of instruction for every child.

Resources

Das, J. P., Naglieri, J. A. , & Kirby, J. R. (1994). *The Assessment of Cognitive Processes: The PASS theory of intelligence.* Boston: Allyn & Bacon.

Kirby, J. R., & Williams, N. H. (1991). *Learning problems: A cognitive approach.* Toronto: Kagan & Woo.

Naglieri, J. A., & Das, J. P. (1997). *Cognitive Assessment System: Interpretive Handbook.* Chicago: Riverside Publishing Company.

Naglieri, J. A. & Gottling, S. H. (1997). Mathematics instruction and PASS cognitive processes: An intervention study. *Journal of Learning Disabilities, 30,* 513-520.

Scheid, K. (1993). *Helping students become strategic learners: Guidelines for teachers.* Cambridge, MA: Brookline.

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Paraprofessionals in the Classroom

A Handout for Teachers

by Melissa Fisher Paoni, NCSP, Illinois State University
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Background

The ratio of one teacher to however many students has been a long-standing tradition in the American educational system. Teacher preparation programs train future teachers to provide direct instruction to their students. Over time this preparation has been broadened to include training in dealing with students from other cultures and with disabilities. However, teachers do not receive much preparation in working with other personnel in the classroom. Consequently, the influx of classroom aides (also referred to as teachers' aides, classroom assistants, instructional aides and paraprofessionals) since the passage of Public Law 94-142 has created new challenges, as well as needed resources, for classrooms. The number of classroom aides more than doubled from 1976 to 1992. Currently, classroom aides may be hired for a variety of duties usually including either classroom-wide assistance to teachers or one-on-one support for children with disabilities.

Potential benefits of having aides in classrooms include but are not limited to:

- involving the parents in the instructional program by providing a school-home link
- implementing classroom-wide and individual behavior management plans
- assisting the teacher in identifying specific skills which individual students need to develop
- implementing peer-mediated interventions
- providing a link between regular and special education personnel, particularly regarding inclusion cases

Potential challenges relevant to the classroom aide-teacher relationship may include:

- lack of teacher training for effective use of classroom aide resources
- inadequate training and supervision of aides
- interpersonal difficulties caused by aides not being employed to optimal advantage as well as personality conflicts; lack of mutual preparation time
- negative perceptions of the aide's abilities by the teacher or vice versa
- conflicts regarding duties

What Can I Do as a Teacher?

To create a mutually beneficial team, which will maximize educational resources and have the most positive impact on students' learning, the teacher should act as the leader — or a program manager — of the educational team by defining goals and assigning instructional and behavior management duties to the aide. A few suggestions for increasing the team's effectiveness from a review of the literature include:

1. ***Selection.*** Include the teacher in the selection process.
2. ***Communication.*** Set aside time, at least weekly, for planning with the aide. Provide a flexible, helpful, supportive atmosphere and be open to suggestions that may enhance team process. Maintain a record of these conferences to serve as guide for planning, recording progress, and facilitating communication.

3. **Structure.** The aide position needs to have a job description which delineates instructional, resource, organizational, behavior management and clerical duties, as well as establishing boundaries and job performance criteria.
4. **Training.** Ask the administration for training via workshops or inservice programs which address the aide-teacher team.

Resources

Gerlach, K., Pickett, A. L., Vasa, S. F., & Steckelberg, A. L. (Eds.). (1992). *Strengthening the Partnership — Para-educators Working Together: Issues, Roles and Responsibilities: A Guide for the Teacher and Para-educator* (resource manual). Bremerton, Washington: Olympic Educational Service District #114.

Simon, S., & Spangrud, L. (1992, December). *Paraprofessionals and Teachers: Effective Partnerships for Better Services.* (Booklet distributed at seminar sponsored by Project Apples, Rock Falls, IL).

Goodman, G. (1990). Utilizing the paraprofessional in the mainstream. *Support for Learning, 5,* 199-204.

Haring, K. A., Saren, D., Lovett, D. A., & Shelton, M. N. (1992). A study of the demographic and attitudinal differences between paraprofessionals and teachers in self-contained special education classrooms. *Journal of Developmental and Physical Disabilities, 4,* 51-73.

Simon, S., & Spangrud, L. (1992, December). *Paraprofessionals and Teachers: Effective Partnerships for Better Services.* (Booklet distributed at presentation by Project Apples, Rock Falls, IL).

Storey, K., Smith, D. J., & Strain, P. S. (1993). Use of classroom assistants and peer-mediated intervention to increase integration in preschool settings. *Exceptionality, 4,* 1-16.

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Peer-influenced Academic Interventions

A Handout for Teachers

**by David W. Peterson, NCSP,
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Overview

Peer tutoring and cooperative learning methods facilitate interactions among students in order to increase academic achievement, enhance positive relationships among classmates, and improve attitudes toward school and self. By using these techniques, teachers can better address the individual learning needs of *all* the students in their classrooms.

The Regular Education Initiative (REI) focuses on the need to increase the effectiveness of instruction within the regular education classroom in order to avoid unnecessary labeling and segregation within special education. Peer-influenced interventions, with a strong research base in allocated learning time, assist in meeting the needs of high-risk learners in regular education. Peer tutoring and cooperative learning methods can be used to reinforce and remediate basic skills, to promote critical thinking and to enhance communication and interpersonal skills. The peer tutor role can boost self-esteem for the tutor and can help meet one of the ameliorating conditions cited in research on resilient children — a role for active participation and involvement, a sense of being needed or essential. Although there are differences between peer tutoring and cooperative learning techniques, both are important components of an effective classroom.

Cooperative Learning

Background

A wide variety of cooperative learning methods share an emphasis on setting a goal for a group of students and rewarding the group for their performance. This format actively encourages students to work together, to share information and to support each other's learning. Establishing a group goal motivates students to help one another. Research also suggests rewarding the group based on the combined performance of the individual members of the group. This helps ensure that no one member of the group does all the work. Teachers should base the group's reward or recognition on each student's learning within the group.

There is some controversy regarding the importance of social interaction in cooperative learning in order to promote achievement. However, students do achieve more if they give and receive help in response to other students' requests. The peer tutoring that can go on in groups may help students "think aloud," may lessen student anxiety in learning, or may be more easily understood than instruction provided by the teacher.

Implementing Cooperative Learning Programs

Selection of a Program: Start small. Teachers should try one method in one curriculum area. Next, teachers should consider what goal(s) they wish to achieve: increase achievement, improve self-esteem, improve student relationships? Different methods will achieve different goals. In addition, some methods are more appropriate for certain subject areas than others. Finally, those methods employing more explicit peer tutoring are easier to implement with less mature learners.

Setting Up Cooperative Groups:

- *Group Size*: Younger students or those less experienced in group work should be placed into small groups initially. Limited material to be shared and limited time for group work also require smaller groups.
- *Arrangement of Classroom*: Arrange classrooms so that group members can see and hear each other. Also, students should be able to move from cooperative groups to individual work sites throughout the day.
- *Assignment of Students*: Generally, heterogeneity in groups (having students of varying ability, race, or sex) is important. Whenever possible, teachers should assign students (i.e., rank order on achievement) to mixed groups.
- *Measurement of Performance*: The performance of the group may be measured by combining individual scores, assigning points for cooperative behavior in groups, randomly selecting and grading one student's paper from the group, or grading a group paper or presentation.
- *Individual Accountability*: In order to ensure that every student in the group participates, teachers can assign each student one part of the group task, and can assign each student a role in the group or can use the results of individual tests to determine group rewards/recognition. Roles might include Leader (keeps group on task and reports to teacher), Praiser/Includer (responds to others' efforts and makes sure all members participate), Recorder/Reporter (keeps written record and reports product to class) and Timekeeper.
- *Parent Communication*: In order to respond to possible parent questions or concerns, teachers should develop a communication plan. A letter, newsletter or meeting with parents before cooperative learning is implemented is recommended.
- *Group Skills*: Students may need to be taught how to work cooperatively in a group. Teachers can initially give students nonacademic tasks in a group, have students observe a group effectively working together, or establish contingencies for appropriate group behavior. They may need to specifically teach active listening, giving feedback, asking questions and including reluctant members.

Peer Tutoring

Background

Peer tutoring contrasts with cooperative learning in that it usually involves students working in pairs, one as the tutor, and the other as the student. Peer tutoring increases student achievement for both partners by reinforcing ongoing classroom instruction, remediating skill deficits and providing additional practice opportunities which are essential to effective learning.

Research clearly supports the effectiveness of peer tutoring, especially when programs are highly structured and sequentially organized. Peer tutoring is effective with students of all ages and abilities including "high-risk," learning disabled, behavior disordered and mentally handicapped students. Peer tutoring can be used in almost any content area, but is most frequently used in reading, math and spelling.

Implementing Peer Tutoring Programs

Tutor Training: Thorough tutor training will often ensure a successful program. Training programs should specifically teach tutors how to: 1) organize and use instructional materials; 2) maintain the "student's" attention during the sessions using *positive* techniques, as well as use teaching behaviors which are positive and do not punish mistakes; 3) set clear expectations for the student's learning; 4) give clear directions regarding the ways in which students should respond (i.e., "when I point to the problem, you give the answer quietly"); 5) use proven error correction methods (e.g., model, lead, test), as well as cues and prompts; 6) praise correct responses; and 7) measure student progress and maintain records. It is important that tutors, regardless of ability level, role play and practice these skills before beginning tutoring.

Establishing Tutoring Pairs: While common sense should prevail in the selection and assignment of tutoring pairs, the following guidelines are suggested: 1) older students who are relatively proficient in the subject matter will probably be the best tutors; 2) nevertheless, do not rule out tutors with skill deficiencies. They can be paired with younger "students" (cross-age tutoring) to minimize their deficits and improve their skills as they teacher; 3) select tutors who are sensitive to others, responsible, and motivated to teach (seek the recommendations of other teachers); and 4) monitor compatibility during the program and do not hesitate to make changes if students are not doing well together.

Lesson Content: Lesson content should be closely related to the skills being taught in the classroom to promote generalization and the efficiency of classroom learning. Select key skills that are important to continuing success in the selected subject matter and ignore supplementary skills that are not essential. Develop lesson materials that: 1) are easy to use, 2) enable children to respond in a consistent fashion, and 3) provide tutors with structure. Drill and practice tasks are sometimes easier for younger children.

Supervising, Scheduling and Maintaining the Program: It is important to closely supervise tutoring, especially in the early stages of the program. Observe and, if necessary, provide additional instruction in praising, effective teaching, etc. Students may also need assistance in record keeping. Schedule tutoring sessions in collaboration with other teachers to minimize conflicts. If possible, tutoring should occur on a daily basis and sessions should be brief (20 to 30 minutes). In order to maintain a smoothly operating program, provide regular recognition for tutors and students. Hosting a luncheon, sending notes to parents and sending articles to the school newspaper or board newsletter will all provide much deserved recognition to students and teachers for their hard work.

Evaluating Student Progress

Those using peer-influenced interventions should include a method for measuring students' gains. We strongly recommend the use of direct, daily measurements rather than norm-referenced tests. For example, measuring the number of words read correctly during a one-minute timing (cwpm) will provide a more accurate and sensitive measure of reading progress than any standardized test. Classroom test scores can also be evaluated to determine if carry-over is occurring. Teachers may also wish to ask students to evaluate the program and their own progress, and teacher-made attitude surveys can be used to assess affective gains.

Resources

Ehly, S. (1986). *Peer tutoring: A guide for school psychologists.* Washington, DC: National Association of School Psychologists. A step-by-step guide with useful tips on training tutors. An accompanying videotape is also available from NASP.

Foot, H.C., Morgan, M.J., & Shure, R.H. (Eds.). (1990). *Children helping children.* Chichester: John Wiley.

Jenkins, J. R., & Jenkins, L. M.(1981). *Cross-age and peer tutoring help for children with learning and behavior problems.* Reston, VA: Council for Exceptional Children. An excellent summary that is a must for anyone starting a tutoring program.

Kagan, S. (1989). *Cooperative learning: Resources for teachers.* Laguna Niguel, CA: Resources for Teachers. An excellent compilation of practical cooperative learning techniques.

Slavin, Robert E. (1995). *Cooperative learning: Theory, research and practice (2nd Edition).* Allyn and Bacon.

Internet Resource

Getting Started with Cooperative Learning:
<http://www.crocker.com/~rebotis/profsubjects/cooperativegetting.html>

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Peer Tutoring Procedures for General Education Classrooms

by George J. DuPaul, Ph.D.
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Rationale

Peer tutoring can be defined as a structured dyadic interaction between two students wherein one student provides the other with academic instruction, presents items of an academic task, corrects errors and/or provides feedback about the accuracy of responses. A number of peer tutoring models have been discussed in the research literature, with the most widely studied being Class-Wide Peer Tutoring (CWPT; Greenwood, Delquadri, & Carta, 1988) and Reciprocal Peer Tutoring (Fantuzzo, King, & Heller, 1992). In addition, tutoring dyads can be composed of same-aged peers or students of differing ages, referred to as cross-aged tutoring.

Peer tutoring may be an effective instructional technique for a number of reasons. First, peer tutoring increases student's opportunities to respond to academic material relative to teacher-led instruction or group activities. Second, the content of academic task material can be individualized for each student in the pertinent curriculum. Third, peer tutoring enables students to receive immediate feedback about the accuracy of their work. This allows for ongoing positive reinforcement for accurate responding as well as the opportunity for students to correct errors instantaneously. Fourth, receiving feedback from a peer may increase student motivation to attend to and complete independent seatwork. This may be particularly important for students who exhibit attention difficulties and related behavior problems.

The above factors suggest that peer tutoring may enhance the academic achievement of participating youngsters compared to more traditional forms of instruction. Indeed, various peer tutoring programs have been found to increase task engagement rates and achievement levels of both low- and high-functioning students (see for review, Greenwood et al., 1991; Mathes & Fuchs, 1994). In particular, longitudinal investigations of CWPT have found the latter to exert beneficial effects on academic achievement beyond the grade level where tutoring strategies were employed (Greenwood, Terry, Utley, Montagna, & Walker, 1993). Finally, peer tutoring strategies appear effective for all grade levels ranging from preschool through high school, although most of the empirical work on these techniques has been conducted in elementary school settings.

Getting Started

Initially, these procedures are best implemented by a knowledgeable trainer or district consultant. The best way to begin a peer tutoring program is to identify teachers who are interested in learning about peer tutoring or who are already using similar procedures (e.g., cooperative learning) in their classrooms. Methods to identify interested teachers could range from informally polling faculty to conducting a more formal survey of interests and attitudes towards peer tutoring. Alternatively, an interested teacher might be identified in the process of providing consultation about a student who is struggling academically. That is, CWPT may be one method to address the academic or attentional difficulties of a youngster during the pre-referral intervention process.

Once an initial classroom is identified, students are trained to engage in peer tutoring procedures for one academic subject (i.e., reading, math, or spelling). The specific subject matter should be selected by the teacher based on what (s)he feels would best meet the classroom needs; however, it may be easier to initiate peer tutoring for math or spelling skills before training the class to do CWPT for reading. If possible, once the teacher and students in this initial classroom are competent and comfortable with CWPT procedures, the class could be videotaped using CWPT (after parent permission is obtained). This videotape could then be used for training purposes with further classrooms.

The success of CWPT in the initial classroom can be communicated to other teachers in the school both informally and by providing a brief inservice presentation on the rationale and efficacy of peer tutoring. Ideally, the classroom teacher familiar with CWPT procedures should serve as a co-presenter for this inservice training in an effort to maximize the recruitment of additional faculty. Care should be taken to point out the strengths and limitations of CWPT during this presentation. For instance, teachers should be told that these procedures are not meant to take the place of teacher-led instruction but rather serve as an alternative to more traditional drill-and-practice activities (e.g., independent seatwork).

Training Teachers and Students in CWPT

The first step in helping a teacher to implement CWPT is to meet with him or her for about 30 minutes to provide an overview of the procedures and to describe the responsibilities of the teacher and students during peer tutoring (i.e., review procedures outlined in Implementation section below). At the end of this initial meeting, the teacher is provided with a written description of peer tutoring procedures, such as a copy of this article or, ideally, a copy of the CWPT manual (Greenwood, Delquadri, & Carta, 1988). If possible, it is helpful to have the teacher view a videotape of a classroom using CWPT or visit a class during a peer tutoring session.

Another 30-45 minute meeting with the teacher is held approximately one week later after (s)he has had a chance to read the written description and observe a CWPT session. At this next meeting, teacher questions about procedures are addressed and methods to train students in CWPT (see below) are explained. A schedule is discussed wherein baseline data are collected for one week prior to implementing peer tutoring. The types of measures to be used to determine effectiveness of the program are outlined (see Outcome Measures section below). The trainer/consultant should plan on making weekly visits to the classroom during the initial stages of implementation to assess adherence to CWPT procedures and to address any difficulties encountered with peer tutoring.

Students are trained in CWPT over three to four 20-30 minute sessions held over several days. During the initial training session, the teacher explains CWPT in the context of a game that will help all students to perform better in a particular subject matter (i.e., math, reading, or spelling depending on which has been selected as the initial target area). It may be helpful to use a basketball analogy to emphasize teamwork and the awarding of points for correct responses (e.g., correct answer warrants two points like a field goal in basketball, correcting an error is worth one point like a free throw).

Tutoring procedures are explained (see Implementation section for details of these procedures) and, if possible, the class views short clips of a videotape of another classroom using CWPT. This initial session ends with a discussion of the need for cooperation among teammates in order to succeed. In fact, to carry the sports analogy one step further, the terms "coach" and "player" may be substituted for "tutor" and "tutee", respectively. These terms are easier to understand and emphasize the teamwork aspects of peer tutoring.

The second training session begins with students practicing gathering materials (e.g., tutoring sheets, pencils) and moving to their partners in an orderly fashion. The teacher provides signals for students to follow three steps: (a) stand at desk; (b) pick up tutoring materials; and (c) move to sit next to or across from partner. Next, the teacher and a volunteer student model a successful and unsuccessful tutoring interaction. The mechanics of presenting each item, waiting for a response, providing feedback and awarding points are demonstrated for a variety of scenarios (e.g., correct answer given, incorrect answer given, no response to question).

During the third training session, students practice moving to partners and then tutor each other with sample items. Midway through the session, the teacher signals each tutoring dyad to switch roles wherein the tutor becomes the tutee and vice versa. The teacher visits each pair of students to offer specific feedback as to what is being done correctly as well as to correct errors in tutoring procedures. Additional practice sessions may be necessary for some classrooms, particularly those in the lower grades (i.e., Grades 1-3). It is helpful for the trainer to attend the last training session to offer guidance to the class and to help the teacher decide if students are ready to formally begin CWPT.

Implementation

Prior to the initial tutoring session, the teacher divides the class roster in half to form two teams (e.g., the "red" and "blue" teams). All students participate, including those with disabilities. Within each team, students are placed into pairs according to the anticipated degree to which they will cooperate rather than strictly by similarity of academic functioning. The makeup of pairs and teams are switched weekly to build in variety and to enhance motivation (i.e., maximize probability that all students will get to be on a winning team). One member of each pair is designated as a "mover" and will be asked to gather materials for the pair prior to moving to his or her partner.

Implementation steps are briefly described for peer tutoring in math and spelling. Each tutoring pair is provided with two point sheets, a tutoring sheet containing items to be practiced (e.g., a list of 20 math problems with answers) and a help card (colored index card to signal teacher for assistance). Following a signal from the teacher, the student designated as the tutor will presents the first item on the tutoring sheet to the tutee. If the tutee responds correctly, the tutor provides praise and marks two points on the point sheet by placing a slash mark through the first two numbers on the sheet. If the tutee answers incorrectly, the tutor provides the correct answer. The tutee then states the correct answer three times to earn one point.

Successive items are presented to the tutee for 10 minutes, after which the teacher signals each pair to stop. Students switch roles (i.e., student who was tutor is now tutee and vice versa) and follow tutoring procedures for another 10 minutes. Tutoring scripts (i.e., list of math or spelling items) should be of sufficient length to allow most pairs to go through the list of items at least twice during each 10-minute period. The number of items may need to be adjusted if most dyads are not able to accomplish this during the time provided.

While students are tutoring each other, the teacher walks about the room monitoring each dyad, answering questions and providing one to five bonus points for pairs that are following tutoring rules. For example, the latter may include: (a) work hard; (b) give praise; and (c) pay attention. Of course, these rules will vary according the age and needs of the specific students.

At the conclusion of each tutoring session, each student is asked to note the last number slashed through on his or her point sheet and to write this number on the back of the sheet. The teacher then asks each student, one at a time, to report the number of points earned. Point totals are displayed on team posters so that each student can gauge his or her progress over the week. At the end of the week, team points are totaled and the team with most points is applauded by the other team.

Tutoring sessions are conducted for about 20 minutes per day, Monday through Thursday. Most teachers choose to conduct CWPT in 4- to 6-week cycles with several weeks between each cycle. Teachers have reported that this helps to coordinate the use of CWPT with the curriculum and enhances motivation among students to participate.

Ongoing Monitoring

During the initial stages of CWPT implementation, the trainer/consultant should make weekly visits to the classroom to assess adherence to peer tutoring procedures as well as to address any difficulties that may have arisen. A brief checklist of teacher implementation (see attached checklist) should be completed after each visit as a record of intervention adherence. If a teacher is not completing each of these steps in a consistent fashion, this should be corrected as soon as possible.

The most common implementation problems are as follows: First, conflicts may develop in one or more of the dyads. This should be addressed by reminding the pair of students about tutoring responsibilities, monitoring their activities closely, providing bonus points to other dyads that are cooperating and, if all else fails, by splitting up the conflictual dyad before the next scheduled change in partners.

A second problem that may arise is that some pairs may cheat by giving each other too many points. Pairs that end up with a large number of points relative to the remainder of the class should be monitored closely for possible cheating. If cheating is discovered, the guilty dyad should lose all of their points for the day and all other pairs should receive bonus points for not cheating.

Another problem that could occur is that some pairs will work slowly and therefore not complete all of the tutoring items at least twice during the session. Such pairs should given tips on how to increase their speed (e.g., tutor presents next item before marking point sheet) as well as prompted and reinforced for greater speed in going through the items.

Outcome Measures

The effectiveness of CWPT procedures can be measured in several ways. Perhaps the most cost-effective way to assess progress in academic skills is for the teacher to administer weekly pre- and post-tests on the material to be practiced that week. Pre-tests are conducted prior to CWPT on each Monday, while post-tests are administered each Friday (when CWPT typically is not conducted). Percentage accuracy on these tests can gauge if the class is profiting from CWPT and which students may require additional assistance. An additional measure of academic skills could be obtained by administering curriculum-based measurement (CBM) probes to several students twice per week. One or two high-, medium and low-performing students could be selected randomly for CBM probes. This would provide a measure of the rate of progress among subgroups of students as a function of CWPT.

At some point it may be helpful to assess the degree to which the teacher and students are satisfied with CWPT by administering a brief satisfaction inventory (see attached handout). Responses to these inventories may highlight the strengths and limitations of procedures wherein the latter could be addressed by modifying the tutoring sessions, as necessary.

References and Suggested Readings

Fantuzzo, J., King, J.A., & Heller, L.R. (1992). Effects of reciprocal peer tutoring on mathematics and school adjustment: A component analysis. *Journal of Educational Psychology, 84*, 331-339.

Greenwood, C.R., Carta, J.J., & Hall, R.V. (1988). The use of peer tutoring strategies in classroom management and educational instruction. *School Psychology Review, 17*, 258-275.

Greenwood, C.R., Carta, J.J., & Maheady, L. (1991). Peer tutoring programs in the regular education classroom. In G. Stoner, M. Shinn, & H. Walker (Eds.), *Interventions for achievement and behavior problems* (pp. 179-200). Silver Spring MD: National Association of School Psychologists.

Greenwood, C.R., Delquadri, J., & Carta, J.J. (1988). *Class-Wide peer tutoring.* Seattle WA: Educational Achievement Systems.

Greenwood, C.R., Terry, B., Utley, C.A., Montagna, D., & Walker, D. (1993). Achievement, placement, and services: Middle school benefits of Class-Wide Peer Tutoring used at the elementary school. *School Psychology Review, 22*, 497-516.

Mathes, P.G., & Fuchs, L.S. (1994). The efficacy of peer tutoring in reading for students with mild disabilities: A best-evidence synthesis. *School Psychology Review, 23*, 59-80.

Note: The CWPT manual and forms may be ordered from Educational Achievement Systems, Inc., 319 Nickerson — Suite 112, Seattle WA 98109; (206)820-6111) for $44.95. 2 Tutoring point sheets and other relevant forms are provided with the CWPT manual.

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Phonological Core Deficits

Academic Interventions For Teachers

by Julie A. Frost
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Overview

Approximately 3% to 6% of all school-aged children are believed to have developmental reading disabilies or dyslexia. In fact, almost 50% of children receiving special education are learning disabled, and reading disabilities are the most common area of deficit. Consequently, extensive literature exists on instruction and remediation methods.

Current research indicates that a large number of children with reading disabilities have "phonological core" deficits. The severity of these deficits varies across individuals, and children with these deficits have been shown to make significantly less progress in basic word reading skills compared to children with equivalent ability. For example, some experts report that between ages 9-19, children with phonological deficits improve slightly more that 1 grade level in reading while other learning disabled (LD) children in the same classroom improve about 6 grade levels. Without direct instruction in phonemic awareness and sound-symbol correspondences, these children generally fail to attain adequate reading levels.

Definitions

Phonological core deficits entail difficulty making use of phonological information when processing written and oral language. The major components of phonological deficits involve phonemic awareness, sound-symbol relationships, and storage and retrieval of phonological information in memory. Problems with phonemic awareness are most prevalent and can co-exist with difficulties in storage and retrieval among disabled children with phonological deficits.

Phonemic awareness refers to one's understanding of and access to the sound structure of language. For example, children may have difficulty segmenting words into individual syllables or phonemes and have trouble blending speech sounds into words. Storage of phonological information during reading involves creating a sound-based representation of written words in working memory. Deficits in the storage of phonological information result in faulty representations in memory which lead to inaccurate applications of sound rules during reading tasks. Retrieval of phonological information from long-term memory refers to how the child remembers pronunciations of letters, word segments, or entire words. Reading disabled children may have difficulty in this area which leads to slow and inaccurate recall of phonological codes from memory.

Assessment

Fortunately, there is some general agreement among educators, clinicians and researchers regarding identifying phonological deficits. Phonological processing impairment is generally identified by significantly impaired performance (generally, a standard score less than 85) on phonological processing tasks. The following include some assessment measures which may be used to identify these phonological core deficits:

Features	*Assessment Procedure*
General reading ability	Metropolitan Achievement Tests — Reading Gray Oral Reading Tests, 3rd Ed. Woodcock Reading Mastery Test:Word Identification
Storage and retrieval	Stanford Binet-4: Memory for Sentences Verbal Selective Reminding Test Rapid Automatized Naming Test Boston Naming Test
Phonological awareness	Woodcock Reading Mastery Test- Word Attack Test of Awareness of Language Segments (TALS) Test of Auditory Analysis Skills (TAAS) Lindamood Auditory Conceptualization Test Decoding Skills Test

Intervention Strategies

- **Teach megacognitive strategies**: Teach the child similarities and differences between speech sounds and visual patterns across words.
- **Provide direct instruction in language analysis and the alphabetic code**: Give explicit instruction in segmenting and blending speech sounds. Teach the child to process progressively larger chunks of words.
- **Use techniques that make phonemes more concrete:** For example, phonemes and syllables can be represented with blocks where children can be taught how to add, omit, substitute, and rearrange phonemes in words.
- **Make the usefulness of metacognitive skills explicit in reading**: Have the child practice them. Try modeling skills in various reading contexts. Review previous reading lessons and relate to current lessons.
- **Discuss the specific purposes and goals of each reading lesson**. Teach the child how metacognitive skills should be applied.
- **Provide regular practice with reading materials which are contextually meaningful**. Include many words the child can decode. Using books which contain many words the child cannot decode may lead to frustration and guessing which is counterproductive.
- **Teach for automaticity**. As basic decoding skills are mastered, regularly expose the child to decodable words so that these words become automatically accessible. As a core sight vocabulary is acquired, expose the child to more irregular words to increase reading accuracy. Reading-while-listening and repeated reading are useful techniques for developing fluency.
- **Teach for comprehension**: Try introducing conceptually important vocabulary prior to initial reading and have the child retell the story and answer questions regarding implicit and explicit content. Teach the child the main components of most stories (i.e., character, setting, etc.) and how to identify and use these components to help them remember the story.
- **Teach reading and spelling in conjunction**: Teach the child the relationship between spelling and reading and how to correctly spell the words they read.
- **Provide positive explicit and corrective feedback**. Reinforce attempts as well as successes.
- **Direct instruction and teacher-child interactions** should be emphasized.

Resources for Teachers

Adams, M.J. (1990). *Beginning to read: Thinking and learning about print.* Cambridge, MA: MIT Press.

Bradey, S. and Shankweiler, D. (Eds.) (1991). *Phonological processes in literacy.* Hillsdale, NJ: Lawrence Earlbaum.

Lyon, G.R., Gray, D.B., Kavanagh, J.F., & Krasnegor, N.A. (Eds.) (1995). *Better understanding of learning disabilities: New views from research and their implications for education and public policies.* Baltimore: Paul H. Brooks Publishing Company.

Pressley, M., & Woloshyn, V. (1995). *Cognitive strategy instruction that really improves children's academic performance (second edition).* Brookline Books.

Wong, B.Y.L. (1991). *Learning about learning disabilities.* San Diego: Academic Press.

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Reading: Developing Positive Attitudes in Children

A Handout for Teachers

by Joann Mullen, Ph.D., NCSP
Trumbull County Board of Education (Warren, OH)

Overview

In the classroom, reading instruction has typically focused on specific skills such as sounding out words and building vocabulary. However, the development of a positive reading attitude is often overlooked. Students with positive reading attitudes tend to be willing readers, enjoy reading and become lifelong readers. On the other hand, students with poor attitudes toward reading may only read when they have to read, tend to avoid reading and may even refuse to read altogether. A student's attitude toward reading may have a profound impact upon his/her overall academic progress.

Background

As students progress from early childhood through their school years, they develop likes and dislikes — including positive or negative attitudes toward reading. Teachers may underestimate the critical role they play in the development and shaping of their students' reading attitude. For example, young students view their teachers as "experts." Therefore, the information and values that teachers share with their students about the importance of reading can significantly affect the attitudes that students develop. Teachers are also role models for their students. By observing both the verbal and nonverbal attitudes that their teachers exhibit toward reading, students will tend to develop and demonstrate similar attitudes. Furthermore, because students (particularly preschool and primary grade children) seek and desire approval from their teachers, they tend to develop the attitudes and values that teachers will praise and reinforce.

What Can I Do As a Teacher?

- Discuss books, articles, and other materials that you have read with your students. By sharing your enjoyment as well as the usefulness of the reading materials, you will convey to your students the significant role that reading plays in your life.
- Be a "reading" role model. During students' sustained silent reading time, you should read too, rather than grade papers, work on lesson plans, etc. Students can then observe for themselves the value you place on reading.
- Provide opportunities for students to be in reading groups based upon interest rather than upon reading level. Students tend to have a more favorable attitude toward reading materials that they find interesting.
- Consider having students share books in a creative manner. Students may find such activities as constructing mobiles, developing drama presentations and using puppets to be more enjoyable than preparing an oral or written book report.
- Provide opportunities to discuss books in pairs or small groups. Peer interactions about books tend to have a positive influence upon students' attitudes toward reading.
- Build a school-wide positive attitude toward reading. Book fairs, book clubs, daily sustained silent reading and involvement of students, parents and community members in reading activities are just some suggestions for generating building-wide excitement for reading.

- Be aware that your own attitude toward reading is most significant in the development of your students' attitudes toward reading. Therefore, you need to examine the value and priority you place on reading in your daily life. How can you convey the enjoyment of reading to your students if you are not a lifelong reader yourself?

Resource

International Reading Association: 800 Barksdale Rd, Newark DE 19704; 302-731-1600.
Information on literacy and reading instruction.

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Reading to Read: An Intervention Strategy Combining CBM and Repeated Readings

Adapted by Peg Dawson, Ed.D., NCSP
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Overview

The method of "repeated readings," which emphasizes the repeated reading of short passages, has been shown to be an effective method of increasing reading fluency in young readers. The approach described in this handout, called Reading to Read (RTR), combines this method with curriculum-based measurement (CBM) as a means of increasing reading fluency and providing concrete feedback to the student about reading progress. The components of this intervention, which can be conducted in brief sessions several times a week, include immediate, corrective feedback, performance feedback, verbal reinforcement, student (self) charting of progress and progression through the curriculum based upon acquisition of prerequisite skills and skill mastery. Instructions for implementing Reading to Read are as follows:

Develop reading materials

Select a passage from each third of each book in a reading series, grades 1 - 4. Even if your school district has moved away from basal series, they usually keep copies of the books in storage and they can be used to develop the passages. Passages should be approximately 100 words in length. If desired, 5 literal comprehension questions can be developed for each passage. Since the goal of this exercise is to develop reading fluency and since reading fluency is highly correlated with reading comprehension, developing questions is not essential unless this is a perceived weakness of the target student.

Establish the target child's instructional level

The commonly accepted criterion for instructional level is that the child can read a passage with 95% accuracy. Establish accuracy by counting as errors the number of different words missed (miscalled, hesitations of more than 3 seconds, and words skipped).

Implement repeated reading intervention

Tell the child, "We are going to work on improving your reading. I'll give you a story to read and I want you to read it as quickly as you can without making any mistakes. We will practice each story until you can read 100 words in I minute without making any errors. Let's start with this story."

- Have the child read the first passage, stopping after exactly 1 minute. If the child pauses over a word for more than 3 seconds, supply the word, ask the child to repeat it, and keep reading.
- Review errors when the passage is completed, then record the child's performance by coloring a bar on a chart with the goal line clearly indicated.
- If the child meets criterion on this passage, present the next higher passage in the sequence. If the criterion is not met, the child rereads the same passage until the criterion is met.
- Repeated readings are continued in this fashion until the session is complete. A reasonable session would include 5 to 1 0 trials per session. Sessions may be conducted 3 to 5 times per week. Data suggest that 10 trials per session is more than twice as effective as 5 trials and that 5 sessions per week is more effective than 3 sessions.

Resources for Teachers

Koskinen, P.S. & Blum, I.H. (1986). Paired repeated reading: A classroom strategy for developing fluent reading. *Reading Teacher, 40,* 70-75.

Shapiro, E.S. (1989). *Academic skills problems: Direct assessment and intervention.* New York: Guilford.

This handout was adapted by Peg Dawson, Brentwood, NH, from the following article: Edwards, R.P., Tingstrom, D. H., & Cottingham, B.J., (June 1993). The development of Reading to Read: A behaviorally based intervention to improve oral reading. Communiqué, *22(3), 24-26.*

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"Slow Learners" in the Regular Classroom

A Handout for Teachers

by Servio Carroll, Ed.S., NCSP
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Background

Slow learners are students with below average cognitive abilities who are not disabled, but who struggle to cope with the traditional academic demands of the regular classroom. Their slower learning rate typically requires accommodations to insure their success in school. These students are typically not eligible to receive special education services or included in Section 504 regulations. Comparatively, because they learn more slowly, they are "handicapped" in the regular classroom to approximately the same degree as students with average abilities when competing with gifted students. Statistically, these children comprise about 15% of the population and a far greater proportion of the enrollment in some schools.

"Slow learners" can be easily misidentified, so it is critical that teachers and parents consider a variety of sources of information before they assume that poor school performance is due to a slower rate of learning rather than to a real disability or situational factors. Results from intelligence tests alone should not be used to confirm that a student has "below average" ability, but should be confirmed or disproved with other information about the student's ability to learn— such as observations in familiar settings, review of school records and test scores, interviews with parents, etc. Students who are significantly behind their classmates academically, and who have not responded well to teacher and parent efforts to stimulate achievement, should be referred for a comprehensive evaluation to rule out a disability (such as learning disability, cognitive impairment) that would qualify the student for special education or accommodations under Section 504. Poor motivation, lack of consistent instruction (due to frequent moves or absences), limited English proficiency and a variety of health factors should also be ruled out as contributing to slow academic progress.

What can I do as a teacher?

The following accommodations may be helpful for not only "slow learners" but for other students who are performing below grade expectations:

1. Expect this child to require 3 to 5 times as much repetition of content as necessary for the "average" students. Basic facts may be adequately covered in the regular classroom but depth and breadth of content will not usually be absorbed unless the concept is reinforced through practical and familiar activities that foster generalization.
2. Slow learners who are underachieving in the basic academic areas may benefit from tutoring at school or privately. The goal of tutoring is certainly not "to get him to grade level" but to help her optimize her abilities, to meet the highest, realistic expectations.
3. It is perfectly reasonable and justified to give the slow learner shorter class and homework assignments, or to break up assignments in order to avoid overwhelming the student.
4. Strive to help the child develop a basic understanding of new concepts rather than require rote memorization of meaningless materials and facts.
5. Use demonstration and visual cues as much as possible. Do not distract with too much verbalization. Often, the use of multisensory approaches is beneficial.

6. Do not force the slow learner to compete with children of higher ability. Try to provide less competitive academic programs that will not cause negative attitudes and rebelliousness towards learning. Cooperative learning groups can foster optimal learning for both low and high achievers while encouraging appropriate social interactions in a heterogeneous group of students.

7. It is important that key, simple concepts be presented to children at the onset of any instructional unit to help provide "advance organizers" of the material that follows. The slow learner may encounter difficulties if too many concepts are presented at one time — keep it simple and focused. Materials, language, directions and verbal information should all be within the child's comprehension. This might require some modification or restatement for the slow learners in the classroom.

8. The slow learning child should be given assignments, particularly in social studies and science, that are highly structured and concrete. Large projects requiring mature organizational and conceptual ability should be eliminated (or substantially modified) and the child should be expected to perform within his capabilities. When working on cooperative learning projects, slow learners should be encouraged to assume responsibility for the more concrete, focused tasks while high achieving students assume responsibility for the more abstract components.

9. Emphasize over-learning and use a variety of incentives and motivators.

10. Provide many opportunities for the child to experiment and practice new concepts with concrete materials in real or simulated situations.

11. At the beginning of any instructional unit, the child should be presented with familiar material. This should facilitate new learning and generalization.

12. Simplify directions given to the child and be sure that directions are understood and remembered by having the child repeat the directions back. Maintenance of eye contact is very important.

13. Some children respond well to the guidance of a friendly but higher performing "buddy" in the class to remind them of page numbers, assignments, tests, directions, etc.

14. Be sure to hold appropriately high expectations for *all* students. This does not mean that you should expect the *same* performance from all students, but that you should encourage all students to "reach" a bit higher each time. Student achievement goes up for *all* students when teacher expectations are relatively high and clearly stated.

15. Encourage parents to be involved in their child's education, through supporting homework, attending school functions, communicating with teachers, etc. Send home frequent notes about the child's accomplishments. Parent involvement enhances performance of *all* students.

Resources

Bear, G. , Minke, K., & Thomas, A. (Eds.). (1997). *Children's needs II: Development, problems and alternatives.* Bethesda, MD: National Association of School Psychologists.

Christenson, S., & Close-Conoley, J. (Eds.). (1992). *Home-school collaboration: Enhancing children's academic and social competence.* Silver Springs, MD: National Association of School Psychologists.

Martin, M., & Waltman-Greenwood, C. (Eds.). (1995). *Solve your child's school-related problems.* Bethesda, MD: National Association of School Psychologists.

Stoner, G., Shinn, M., & Walker, H.M. (Eds.). (1991). *Interventions for achievement and behavior problems.* Silver Springs, MD: National Association of School Psychologists.

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Specific Reading Disability/Dyslexia

A Guide for Multidisciplinary Teams

by Yancey Padget, Ph.D., NCSP,
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Background

The U. S. Department of Education reports that, of the students eligible for Special Education services, 51% have learning disabled as their primary diagnosis. Furthermore, researchers estimate that 80% of these students have a significant deficit in reading. These data suggest that students with learning disabilities in reading comprise the largest category of students involved in the diagnostic and remedial processes of Special Education. These students have been the subject of considerable research over the past 20 years. The findings of these studies have been very consistent and have significant implications for the Multidisciplinary Teams which are responsible for the identification and remediation of learning disabilities.

Differential Diagnosis of Learning Disabilities in Reading

From converging research data it is becoming evident that: 1) Some students with learning disabilities in reading have difficulty acquiring basic skills in decoding and spelling words; 2) other students are able to read the words but have difficulty understanding the meaning of both oral and written communication; 3) some students exhibit problems with both word identification and language comprehension.

The first group of students — those who have significant problems learning to decode and recognize individual words efficiently — have been variously described as having "specific reading disability", "developmental dyslexia", or "phonological core deficit". These terms are used by researchers to distinguish this group of students who evidence adequate intelligence and language comprehension but have a specific and serious deficit in acquiring and applying sound-symbol correspondences to read and spell words. Research has clearly demonstrated that the primary cause of this type of reading disability is difficulty isolating and manipulating the individual *sounds* (phonemes) in *spoken* words. The ability to *listen* to a *spoken* word and divide it into it constituent phonemes is referred to as "phonological awareness", "phonemic awareness", "phonemic segmentation", or "phonological coding". This level of phonological awareness is not necessary for speaking; however, it is the bridge between oral language and written language and necessary for competent reading and writing. Students who have specific reading disability/dyslexia make extremely slow progress in reading and spelling unless the specific nature of this type of deficit is identified and appropriate intervention is provided.

Diagnostic Profile

Differential diagnosis of specific reading disability/dyslexia depends on the relationships among general intelligence, listening comprehension, reading comprehension, word identification, spelling, word analysis and phonological coding. Each of these skills needs to be evaluated with adequate, norm-referenced tests and standard scores need to be compared in considering the diagnostic picture. Students from second or third grade through high school who have specific reading disability/dyslexia, and do *not* have concomitant learning problems or handicaps, evidence the following diagnostic profile:

- *intelligence* quotients which are average

- *listening comprehension* subtest scores which are average
- *reading comprehension* subtest scores which are lower than the listening comprehension scores
- *spelling production* subtest scores which are similar to, or less than, the word identification scores
- *word attack* subtest scores which are similar to, or less than, the word identification and spelling scores
- *phonological awareness* skills which are well below average for age

Observations Which Clarify the Diagnostic Picture

Careful observations of a student's performance, during evaluation and in the classroom setting, can support the differential diagnosis of specific reading disability/dyslexia:

Context Effect: Students with specific reading disability/dyslexia are very skilled in using context cues. They are able to use their average cognitive abilities and language comprehension to support their minimal word identification skills. Therefore, tasks which involve reading sentences and *brief* passages will typically result in better performance than tasks which require reading lists of words.

Word Reading: Students with this type of reading disability are not able to truly understand the basis of the code — that letters (graphemes) represent sounds (phonemes) — because they have been unable to separate each individual phoneme, focus on its sound in isolation, and understand how it forms one half of each sound-symbol correspondence. Therefore, they are unable to actually decode words and they must rely on trying to memorize every word as a whole unit. This typically results in very inconsistent word reading, frequent substitutions of words which begin with or include similar letters, and vague attempts at "sounding out" words which are based on letter-names.

Spelling Words: These students often can memorize assigned words for a weekly spelling test but they do not retain this information. They attempt to spell words the way they sound but are lacking the skills to isolate each sound and know what letter represents every sound. Therefore, they have very poor spelling skills overall.

Word Analysis: Pseudo-words are used to assess a student's ability to apply sound-symbol correspondences to sound out unfamiliar words. Students with specific reading disability/dyslexia have very weak skills in this area and they usually achieve raw scores which are typical for First or Second Grade. They tend to give responses which are real words, even when reminded that they are reading nonsense words. An analysis of their attempts to decode pseudowords typically indicate that they have not mastered any of the phonics patterns involving vowels — they do not know the "short" vowel sounds and they are confused about all "long" vowel patterns and vowel combinations.

Phonological Awareness: Students with specific reading disability/dyslexia in third grade or above are usually able to listen to a spoken sentence and isolate each word or listen to spoken word and isolate each syllable. Some of these students, particularly older students, have the beginnings of phonological awareness and are able to listen to a spoken word of two or three phonemes (*me, hop, cape,* etc.) and isolate each phoneme or substitute a different initial or final phoneme. However, all of these students have considerable difficulty in isolating every phoneme in spoken words of four to six phonemes (*pond, skates, spends,* etc.) and in manipulating medial phonemes. These basic phonological awareness skills are developed by typical students as they progress through Kindergarten and First Grade and they provide the foundation for understanding the code involved in sound-symbol correspondences.

Outdated Ideas Which Cloud the Diagnostic Picture

There are certain notions which are *not* supported by current research but manage, nevertheless, to remain a part of educational lore. These ideas can be confusing to members of the Multidisciplinary Team as they address differential diagnosis and appropriate intervention for learning disabilities in reading. Up to date information is the best way to minimize this confusion; in the interim, the Team should beware the following unquestioned assumptions and outdated ideas which can cloud the diagnostic picture or interfere with communicating their findings to others.

Confusing Idea # 1: *Reading ability consists of word identification skills plus reading comprehension skills.* This assumption has been shaped by how achievement tests are organized and it is not based on research. The "simple view of reading" proposed by Gough and Tunmer — reading is the product of word identification and language comprehension — is much more consistent with current research and it facilitates understanding the relationships among oral and written language skills.

Confusing Idea # 2: *Students can learn to read either by phonics or by a whole-word /sight approach.* For all students, skilled reading and writing depends on either an explicit or an implicit understanding of sound-symbol correspondences. *Typical* students have the requisite skills to learn these patterns if they are explicitly taught or to figure them out implicitly, even if they are exposed only to whole word instruction. Students with a phonological core deficit do not have these requisite skills and they require explicit instruction first to develop phonological awareness and then to understand and apply sound-symbol correspondences.

Confusing Idea # 3: *Students with dyslexia have difficulty reading because they have visual perceptual problems and they see letters and words differently.* Research has consistently demonstrated that these students have age appropriate visual perceptual skills and their reading problems are linked to deficits in phonological processing.

Confusing Idea # 4: *Phonics was tried with this student and it didn't work.* The ability to isolate and manipulate every sound in a spoken word — phonological awareness — is necessary *before* phonics instruction can be meaningful and effective.

Appropriate Intervention

Students with specific reading disability/dyslexia make very little progress in their classrooms in traditional basal series or in whole language programs and they do *not* benefit from participating in these programs in Special Education with smaller groups, a slower pace, more practice, more teacher support, etc. These approaches do not address the phonological core disorder which is the basis for the learning disability and the students remain in the cycle of frustration that results from trying to read and spell words based on memorization and partial information supplemented with context cues. However, these students are able to make significant gains in reading and writing when they are given appropriate instruction. They require intervention which explicitly and sequentially teaches phonological awareness, sound-symbol correspondences, and syllable patterns. A synthetic phonics approach with controlled vocabulary is appropriate because it provides the most support for understanding how the code is manifested in both spoken and written words.

Effective remediation for these students is based on learning each pattern in the language and applying this knowledge to decode and encode all words which fit each pattern studied. Words are studied based on their phonics and syllable patterns rather than their grade-level designations. Most students with specific reading disabilities/dyslexia are able to learn all of the patterns in the language and to read and spell most of the words they will need in high school texts in a period of two to three years when given:

- direct instruction
- in a small group
- for 40 to 60 minutes per day
- for four to five days per week
- in an appropriate program.

Initially it often seems that progress is very slow and it is important to remember that it takes time and effort to remediate the phonological coding problem and enable the students to distinguish and isolate phonemes. It is also important to remember that this approach teaches words across all grade levels. The following guidelines may be helpful to the Multidisciplinary Team members as they work on formulating the IEP.

Progress in the First Year: In the first year of appropriate instruction almost all students who fit the diagnostic profile outlined above master the following skills:

- segmenting phonemes in words of up to six phonemes
- manipulating phonemes in words of four phonemes
- reading and spelling one-syllable words and pseudowords with short vowels, single consonants, consonant blends, and consonant digraphs (closed syllables)
- reading and spelling longer words which consist only of closed syllables

In this first year many students also master the skills below; other students make progress in learning these skills but do not demonstrate mastery till the next year; and a few students are not ready to study these skills until their second year:

- reading and spelling long-vowel/silent *e* words and pseudo-words
- reading and spelling longer words which combine closed syllables and silent *e* syllables

Progress in the Second Year: The cumulative effects of this type of instruction are much more noticeable in the second year of instruction and student gains become evident on grade level word lists and passages. During the second year of appropriate intervention most students master the following skills:

- reading and spelling words with open syllables
- reading and spelling words with *r*-controlled vowels
- reading and spelling words with vowel digraphs and diphthongs
- reading and spelling words with *-le* syllables
- reading and spelling words with inflected endings and basic prefixes and suffixes

Progress in the Third Year: During the third year of instruction the students need to focus on more complex derived words in their reading and spelling. They should also learn how to *independently* use textbooks on tape to support their reading in long assignments and computers for editing to support their spelling of multisyllabic words.

Variations on the Diagnostic Profile

Not all students with specific reading disability/dyslexia fit neatly into the classic diagnostic profile because some of them have additional learning strengths or weaknesses that influence their reading and spelling and alter the diagnostic picture. The variations that the Multidisciplinary Team encounters most frequently are outlined below:

Students with Superior Intelligence: Students with specific reading disability/dyslexia who have scores on IQ tests which are in the Superior or Very Superior range follow the basic diagnostic profile but all of their standard scores are somewhat higher. For this group of students, the diagnostic profile is typically characterized by a wider difference in standard scores for reading words and for spelling words. Their word identification scores are usually average for their age and grade placement and these scores may, or may not, be significantly discrepant from IQ. Spelling scores however, usually are quite a bit lower and are below average for age and grade placement. These students do not always meet state criteria for LD in reading but their difficulties with spelling and other aspects of writing can be documented and they usually do meet the discrepancy criteria for

LD in written expression. Appropriate intervention for these students should follow the sequence for learning the patterns in the language but the emphasis should be on applying these patterns to spell words. These students often have acquired many of the skills listed above for the first year. However, they do have a phonological core deficit and it is important to ensure mastery of segmenting and manipulating phonemes and identifying different vowel sounds in *spoken* words before they go on to study the second year skills and the compensatory skills they will need to be successful in higher education. These students and their parents are often quite frustrated because they recognize the disproportionate amount of time and effort which is expended to complete routine classroom assignments and they are worried about this amount of effort in relation to educational and career goals.

Students with Low Average Intelligence: Students with specific reading disability/dyslexia who have scores on IQ tests which are Low Average or Borderline evidence the same relationships among the standard scores but the actual scores are all lower. The same intervention plan is appropriate but these students often need an additional year to master the same set of goals.

Students who also have Language Comprehension Deficits: Relatively little is known about the diagnostic profile of students who evidence problems with both components of reading — word identification and language comprehension. These students have all of the same difficulties with decoding and encoding which are associated with specific reading disability/dyslexia but they do *not* have the relative strengths in language comprehension. The standard scores for these students follow the basic profile but often fall across a very wide range. Their non-verbal intelligence quotients are a relative strength; verbal intelligence quotients, oral language skills, and listening comprehension are relative weaknesses; and all reading, spelling, and word analysis skills are well below average. Intervention for this group of students needs to focus initially on the word identification aspects of reading as these skills are typically the most delayed. It is appropriate to teach the first and second year skills as outlined above but more time may be needed for mastery. As these students progress, a gradual incorporation of vocabulary development and comprehension skills will be needed. Compensatory techniques, such as taped textbooks and computers for editing, are not very efficient supports for these students.

Younger Students: Differential diagnosis of reading disabilities can be difficult when students are in Kindergarten to Second Grade. However, tests of phonological awareness are currently the most sensitive measures for identifying students who are at risk for reading difficulties. Therefore, it is important to assess skills in segmenting sentences in to words, words into syllables, and words into phonemes and then immediately begin including appropriate instructional activities for the skills which need to be learned. Progress in learning these skills can then become an additional piece of information for the Multidisciplinary Team as the differential diagnostic process continues over time.

Summary

Classifying a student as learning disabled in reading provides *access* to Special Education services; however, differential diagnosis is necessary to identify the basis for the reading disability and to determine appropriate intervention. Because students with specific reading disability/dyslexia typically have average intelligence and average language comprehension, they have many learning strengths on which to build. However, remediation of this type of reading disability cannot be accomplished through traditional basal readers, a whole language approach, or an eclectic mix of activities. These students have been the focus of considerable research for the past ten years and it is clear that specific reading disability/dyslexia is a language-based learning disability which is linked to phonological processing problems and the appropriate intervention is a systematic, synthetic phonics program for reading and spelling.

Resources

Adams, M. J. (1990). *Beginning to read: Thinking and learning about print.* Bradford Books.

Clark, D. B., & Uhry, J. K. (1995). *Dyslexia: Theory and practice of remedial instruction.* Timonium, MD: York Press.

Lyon, G. R. (Ed.) (1994). *Frames of reference for the assessment of learning disabilities.* Baltimore, MD: Paul Brookes.

McGuinness, D. (1997). *Why our children can't read and what we can do about it: A scientific revolution in reading.* Free Press

Learning to Read/Reading to Learn: Helping Children with Learning Disabilities to Succeed (1996). This kit can be obtained through partnership organizations (CEC, IRA, LDA, NEA among others) or through ERIC Clearinghouse on Disabilities and Gifted Education (1-800-328-0272).

Phonics programs

Many synthetic phonics programs limit the distribution or sale of their materials to teachers who have been specifically trained by their organization. The programs listed below are more widely distributed; teacher training is available through the publishers but is not required for purchase of the materials.

Corrective Reading — Decoding (Science Research Associates, Inc., 155 North Wacker Drive, Chicago, IL 60606)

Language! (Sopris West, Inc., 1140 Boston Avenue, Longmont, CO 80501; 303-651-2829)

Wilson Reading System (162 West Main Street, Millbury. MA 01527-1943; 508-865-5699)

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Time Concepts

A Handout for Teachers

by Joseph L. Silverman, Ph.D.
Northampton, MA

Background

The influence of time in our culture is so fundamental and pervasive that we are hardly aware of its impact. It is sometimes difficult to remember that our culture's highly structured organization of time is a historically recent development, and time is dealt with very differently in other cultures. One of the primary means by which children adapt to the social environment is by learning about time, and research supports an extended time perspective to understanding growth in planning and organization, delay of gratification, academic achievement, and mental health.

Despite the pervasiveness and importance of the concept of time, it is difficult to define and describe. St. Augustine, in an often quoted passage, wrote, "What then is time? I know well enough what it is provided nobody asks me; but if I am asked and try to explain, I am baffled." Part of the problem with defining time might be a linguistic one; in the English language, many related but distinct concepts are all referred to as "time." Theorists of time generally agree that it is a natural phenomena and the psychological experience of that phenomenon has physiological, perceptual, cognitive and social aspects.

Children primarily learn about time through the system of clocks and calendars, which psychologists refer to as *conventional time* . Time is difficult for children to learn because it has no physical form. Space, on the other hand, can be directly perceived, and it is measured by use of certain metrics — such as rulers. Clocks and calendars provide the "rulers," or scales, which are used to measure time.

Development

The concept of time is multi-dimensional, and research studies have shown that children acquire an understanding of time at different ages, depending upon the complexity of the tasks involved. Children start learning about time when they are very young, but they do not achieve adult-like understanding until adolescence. Studies have shown that newborns can become adapted to a 3- to 4-hour cycle of feeding, and that children as young as one year are able to remember the proper sequence of 2- and 3-act events. Children begin the process of constructing representations of time between the ages of three to five; at about five years, the child starts to organize the past into a more structured and ordered sequence of events. But from this stage on further organization of time depends largely on the mastery of conventional time divisions. Piaget saw the concept of time as developing out of the coordination of velocity and distance and found that children younger than 8 or 9 confused estimates of duration with speed. As a general rule, children will understand time concepts for shorter durations (e.g., daily events) before they do longer durations (e.g., yearly events).

Language about Time: Language about time is relatively slow in developing, probably due to its syntactic and semantic complexity. Researchers hypothesize that children might have an understanding of time before they have the language to express those concepts. However, children might learn to use "time talk" (e.g., using verb tenses and discussing past or future events) through imitation and reinforcement, and this talk facilitates conceptual development. In general, language about time seems to develop earlier than other aspects of the time concept. This is probably due to the fact that temporal language is primarily ordinal (i.e., before and after) in nature.

Duration Estimates: Estimates of duration vary with the content and context of the experience. As Albert Einstein said in describing relativity, "When you are courting a nice girl an hour seems like a second. When you sit on a red-hot cinder a second seems like an hour." In addition, adults understand that "objective" time moves uniformly, and that time exists independent of their subjective perception of it. But young children lack this concept, and for example will believe that time passes at a much slower pace during some activities versus others. Researchers have found that, for both adults and children: (a) absorbing tasks shorten the impression of time; (b) increasing the frequency or number of events within a duration lengthens the estimation of that duration; and (c) certain situations, such as frustration with waiting or anticipation of a pleasant experience, make an interval seem longer. For short durations, intervals filled with a higher frequency of events make the perception of that interval seem longer, but for long durations relatively empty intervals are judged as longer in duration.

Time Perspective: Time perspective refers to the integration of the present with the past and the future. Children are generally viewed as present-bound and, as they mature, their perspective broadens to include further distances of both the past and the future. Although there has been little research on time perspective in children, studies suggest that children with learning disabilities, ADHD and emotional disorders have a restricted time perspective as compared with typical children.

By age 4, children are able to sort events in the past according to relative recency. Children start to learn about conventional time at about age 5, but the integration of that knowledge with memories of events occurs later. Time memory is aided by the use of temporal "anchors," an easily remembered event against which other events can be compared. Studies suggest that children begin to use such anchors (e.g., birthdays) at about age 7 or 8. The capacity to locate memories relative to each other by reference to conventional time markers seems to occur sometime after age 8.

Knowledge of Conventional Time: Children are generally introduced to the concepts of conventional time when they begin school. Children usually learn the days of the week and the months of the year as a verbal list of terms. However, this type of representation is not very efficient for many types of problems, such as determining the distant between nonconsecutive months or calculating backwards. Research suggests that, as children develop, they learn to think about time using spatial images (e.g., a mental picture of a clock), and these images are more efficient than verbal-lists for many temporal problems.

Children start learning to read a clock at about 4 years, but the skills are still developing in speed and ease at 10 years. Most children can read the hour times by age 6, 5-minute intervals of clock-time by age 7 or 8, and one-minute intervals between 8 and 10 years of age. However, it is not until age 11 or so that the child really understands that clock time is an arbitrary abstraction. In one study, 10-year-old children did not understand that when the clock is pushed ahead one hour for daylight savings time, they did not get an hour older.

Research has shown that children as young as 3 or 4 years of age have some understanding of the relative duration between events; for example, that the interval of time between having lunch and going to bed is longer than the interval between waking up and having breakfast. Children are able to sort a series of cards showing daily events into correct temporal order by approximately age 4 and can produce a correct backward order by age 5; however children need to be several years older before they are able to do a similar task with longer time periods — such as days of the week and months of the year. Children in kindergarten have an understanding that historical events took place in the past, but dates have little meaning for children before third grade; and although third- and fourth-graders typically understand the numerical basis of dates, only by about fifth grade do students connect particular dates with specific background knowledge.

An advanced stage in the understanding of conventional time is knowing the degree to which time systems are arbitrary; even adults do not always have this concept. When England adopted the Gregorian calendar in 1752, and the date of September 3 was changed to September 14, rioting broke out among farmers concerned about the "lost" days in their growing season. Children are about 11 years old before they understand that clock changes do not influence natural processes and that there can be a novel calendar that begins at a different time and has more seasons than the conventional four-season system.

What Can I Do as a Teacher?

- The time perspective of young children will be enhanced by frequent reference to events in the past and future. References should include both recent and distant events and use conventional time units.
- When teaching about clocks and calendars, teachers can encourage children to use both verbal lists and spatial images, such as by using time-lines. Time-lines for different scales of time, such as the lifetime of a parent or that of our country, can be compared. Children can be taught to locate events on the time-line with distances between them that correspond to appropriate time intervals.
- Schools often celebrate birthdays; notice can also be made of half, and even quarter, birthdays. Experiments could be performed regarding estimation of duration. Children could be asked how many seconds have elapsed for durations with different activities filling them. The phenomenon that different experiences can have differently perceived durations can be pointed out and these experiments can be used to teach the difference between objective time and subjective time.
- For older students, an interesting long-term project could be calendar-creating. If they were lost in time and didn't know what date it was, how would they go about determining the date? Or, if they had the job of creating a new calendar, how would they go about doing so?

Resources

Arlin, M. (1990). What happens to time when you sleep? Children's development of objective time and its relation to time perception. *Cognitive Development, 5*, 71-88.

Barton, K. C. & Levstik, L. S. (1994). *"Back When God Was Around and Everything": Elementary Children's Understanding of Historical Time*. (Report No. PS022462). (ERIC Document Reproduction Service No. ED370716)

Friedman, W. J. (1990). *About Time: Inventing the Fourth Dimension*. Cambridge, MA: MIT Press.

Friedman, W. J. (1992). Children's time memory: The development of a differentiated past. *Cognitive Development, 7*, 171-187.

Piaget, J. (1971). *The child's conception of time*. New York: Ballantine Books.

Internet Resource

http://hea-www.harvard.edu/ECT/the_book/Chap3/Chapter3.html#tm

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Time On Task

A Strategy for Teachers

by Stephen E. Brock, Ph.D., NCSP
Lodi Unified School District (Lodi, CA)

Introduction: This handout describes a token economy program designed to increase on-task behavior. Program components include immediate reinforcers, several daily mini-conferences with the teacher, and daily and weekly rewards. Before beginning this program, teacher and student should review on-task behavior expectations. It is recommended that teachers make sure students understand what it means to *begin work immediately, work quietly, remain seated, ask good questions, complete work, work carefully and follow instructions.* Understanding these seven on-task behaviors is critical because the program specifies that target students be reinforced for displaying them.

Immediate Reinforcers: As frequently as possible, during the school day, the student should be given immediate verbal praise whenever any of the seven on-task behaviors are displayed. For example, the teacher might say: "I like the way you began work right away!", or, "I like how quietly you are working!"

Mini-Conferences: At several previously specified times during the day, the teacher has a one to two-minute mini-conference with the student. Making use of an on-task sticker sheet (Figure 1), the teacher gives the student a sticker and verbal praise for each of the seven on-task behaviors demonstrated during the just completed instructional period. For example, the teacher might say: "You completed your work! You've really earned this sticker!" Also, encouragement and instruction regarding on-task behaviors not displayed should be offered. For example, the teacher might say: "Looks like you added instead of subtracting on some of these problems. That's not working carefully and I can't give you this sticker. I know you can earn this sticker next time! Remember to pay attention to the operation."

The number of mini-conferences held is a decision to be made by the teacher. As a general rule, the more conferences held the better. However, it is essential that it be feasible for the teacher to consistently provide all scheduled conferences. A natural time for these conferences is before each recess and lunch period, and at the end of the school day.

Daily Rewards: Using this program the student can receive a maximum number of stickers per day (7 times the number of mini-conferences). Before implementing the program, teacher and student should set a daily goal for number of stickers to be earned. This goal should be written on the on-task sticker sheet (Figure 1). During the initial stages of the program the daily goal should be set low and at a level that ensures success. The daily total of stickers necessary to earn the reward may be increased as the student's on-task behavior improves.

If the student reaches the on-task behavior goal, one or more daily rewards would be given. A behavior contract should be written to specify what rewards are earned when goal is met. One reward possibility, that would serve the dual purpose of facilitating home-school communication, is to send home a positive note to the student's parent(s) (Figure 2). This note encourages the parent(s) to further reinforce the positive on-task behaviors seen at school.

Weekly Rewards: As an optional component of this program, teacher and student may also set a weekly goal for the number of stickers to be earned. If the student reaches this goal a reward would be given. This reward might include the privilege of participating in a special activity on Friday afternoon. For example, the student may earn the privilege of eating lunch with the teacher. During the initial stages of the program the weekly goal should be set at a level that ensures success. The weekly total of stickers needed to earn the reward may be increased as the student's on-task behavior improves. Figure 3 provides an example of a weekly sticker total contract.

Concluding Comments. Counseling from the teacher during the mini-conference and not receiving the rewards specified above would serve as the contingency for off-task behavior. In implementing this program, it is important to remember that consistency is critical. This is especially true during the early stages of the program.

Figure 1

ON-TASK STICKER SHEET

Instructional Period	Begins work immediately	Works quietly	Remains seated	Asks good questions	Works carefully	Follows instructions	Completes Assignments	**Total**

My daily total. .... ☐

My daily total goal for this week .... ☐

If I meet my daily total goal, I will earn ____________________________________

____

Figure 2

SUPER WORKER REPORT

Date:

Dear ______________________,

Your child had a good day today. The on-task behavior goal was met. It would be appropriate for you to do something special for your child tonight to reinforce this good work.

Sincerely,

Classroom Teacher

Figure 3

WEEKLY STICKER TOTALS

Day	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Sticker Total					

My weekly total goal is .... ☐

If I meet my weekly total goal, I will earn ____________________________________

____

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Tutoring

A Handout for Parents

by Gregg E. Drevno, Talbot County (MD) Public Schools
and Bonnie B. Nelson, Queen Anne's Public Schools (MD)

Tanya hopes to attend a small liberal arts college next fall. Her "D" in Spanish may prevent her from reaching this goal. She and her parents meet with her language teacher who suggests hiring a tutor.

Jacob often dissolves in tears after spending 2 hours completing his reading homework with his parents help. Since meeting with the teacher, who said Jacob was below grade level in reading, his parents have tried to provide him with additional help. The teacher allows him extra time to finish his work, but learning to read continues to be a problem for him. After many frustrating evenings, his parents decide to employ a tutor.

Background

Parents employ tutors to help their children succeed in school. Generally, tutors are either self-employed or work for a company in the business of supplementary education. It is fair to expect that tutors have the necessary interpersonal skills, education and experience needed to give a young person the individual help they need. Young people are tutored for variety of reasons: to improve a grade and performance in a subject area (for example, reading or math), to supplement instruction at school (for example, practice in speaking a foreign language) or to prepare for school/college entrance examinations. When faced with a youngster who is struggling in school, or one who wants the opportunity to improve his/her knowledge in a subject area, parents have to decide if tutoring can make a difference. Tutoring is generally costly in terms of money and time, and may yield only limited results. The decision is seldom easy and has to be made carefully. Parents will need to consider why and when their child requires a tutor, how to select one, and what to expect from the tutor. The following is intended to help parents weigh these considerations.

What to Expect from the Tutor

- A discussion of how tutoring will benefit your child
- Realistic goals; not grand promises and high price tags
- Knowledge of and experience with individualized approaches of instruction
- Sessions that engage your child in varied and interesting activities
- An honest report of your child's progress
- An enthusiastic and professional attitude toward you and your child
- Efforts that yield measurable change in the your child's performance at school. Tutoring should lead to improved skills or abilities in the intended setting (for example, classroom).

Tutor's Qualifications and Responsibilities

- Willingness to provide credentials and references of experience
- Provides a learning environment and uses teaching methods that are safe, sound and appropriate
- Available to coordinate with classroom teacher as way to assist your child

How to Find a Tutor

- Ask at your child's school — a mentor, volunteer or staff person might be available
- Yellow pages or newspaper advertisement
- Referral from teacher, school psychologist, guidance counselor, etc.
- Referral from friend, or knowledgeable person in the community (physician, mental health counselor, clergy person)
- Local university or college

Cost of a Tutor

- Variable, but parents need to determine if their budget can afford this service or help
- May be available at no cost or on a sliding scale
- Will likely vary by the kind of service provided by the tutor or tutoring company (testing, consulting with classroom teacher, computerized instruction, etc.).
- Cost may be lowered if your child is tutored in a group; the potential benefit here is your child may also learn from the other students.

How Parents Can Support the Tutor

- Be sure you and your child can commit to the time requirements of tutoring.
- Be on time for sessions.
- Prepare your child to be a participant in the tutoring by discussing with him/her that it is similar to school (rules, etc.) and the purpose of such assistance.
- Help and encourage your child to practice and use those skills, etc. taught during tutoring.
- Reinforce and praise your child for participating and using what is learned during sessions.

Is Tutoring the Best Option?

Parents should realize and accept that under the best of circumstances their child's abilities and skills may improve slowly. However, in a reasonable amount of time, parents will need to assess if tutoring should continue or if some other alternative is needed for their child. In some situations a child may need more help, or something different at school. To determine the best option, meet with your child's teacher. It may be that your child *needs to put forth more effort and attention to his/her school work,* or he/she requires *more focused help* or *specialized assistance* at school. Some of these forms of help are obtained by conferencing with or requesting that your child be evaluated by a member of the student support staff, for example, a school psychologist.

Tutoring or supplemental education is a growing industry. In many circumstances it uses the latest methods and forms of instruction, and like many other industries it is going international. The objective of tutoring is to help your child acquire skills and master concepts that raise his/her level of performance. Parents who seek the services of a tutor can do a great deal to promote and ensure that this overriding objective is achieved by being a prudent consumer of tutoring services.

Resources: Helping your Child in School

Levine, M. E. (1994). *Educational care.* Cambridge, MA: Educators Publishing Service.

Martin, M. , & Waltman-Greenwood, C. (Eds.) (1995). *Solving your child's school-related problems.* New York: HarperPerenniel.

Rimm, S. (1996). *Dr. Sylvia Rimm's smart parenting: How to raise a happy, achieving child.* New York: Crown Publishers

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Word Retrieval: Hidden Disability

A Handout for Teachers

by Shirley Miguel, Ph.D.
Fresno County (CA) Department of Education

Background

Word retrieval, the ability to efficiently choose the words needed for communication, is based on storing and then accessing verbal information from "long-term storage." There has been debate in the literature about whether word retrieval impairment is due to limited auditory memory or poor semantic organization. Current research supports the idea that word retrieval difficulties are usually based on auditory memory deficits, especially for unrelated data, and difficulties in organizing the information once it is retained. Problems may be experienced in recalling single words or in extended conversation. In severe cases, children may have difficulty recalling specific words in all situations. Although children with word retrieval impairment have problematic auditory memory, they may have excellent recall of activities previously experienced.

It is difficult to determine the actual cause of word retrieval impairment. Genetics, middle ear infections, upper respiratory allergies and birth trauma have all been identified as possible culprits. At this time however, the primary source of word retrieval impairments is unknown. Word retrieval disabilities may be seen in combination with other language impairments or learning disabilities. However, this impairment is also experienced as an isolated and specific deficit.

Development

Word retrieval problems can be observed at any age, but the disability is more readily apparent in young children. With fewer word choices, experience with specific topics and compensatory strategies at their disposal, children at the kindergarten through third grade level can more easily be observed in their verbal struggles. They may repeat words or encounter significant verbalization difficulties, and even be misdiagnosed as stutterers. Their responses may be "in the ballpark" but not specifically accurate. Those who avoid the difficult task of verbalizing may be identified as shy, withdrawn or as having poor social skills. They may tend to use facial expressions or gestures instead of words.

At older ages, children not only continually increase their quantity of new words, they also learn techniques to "stall" while they think of alternate ways to say what they mean. Adolescents, often pressured to sound like their peers, also "mask" verbal impairments by consistently using vague descriptors such as "thing," "stuff," "deal," or "like". Their sentences, while overly simple in structure, tend to be accurate. Adolescents with this disability may also display excellent language in social situations or in talking about topics of their choosing. In school, they may complain that teachers talk too fast or that the teacher or subject matter is "boring."

Thus, many factors can obscure accurate identification of word retrieval impairment. The classroom teacher can serve as a valuable referral source. Once the student is identified as having a word retrieval deficit, teachers can provide assistance in practicing effective retrieval strategies. However, language/speech pathologists, teachers and parents are often confused by the child's overt behaviors.

What Can the Teacher Do?

Observe: The classroom teacher, an excellent referral source, can observe the child in varied situations; i.e., spontaneous conversation, retelling familiar versus unfamiliar sequences of events, and verbalizing under pressure. This behavioral characteristics chart should prove helpful in identifying word retrieval difficulties. Auditory memory can be observed in the classroom when the student follows directions or attempts to recall specific words (semantic information) — dates, names, quantities, locations. These students often retain the information during instruction, but they are unable to retrieve it later on tests.

Characteristics of Word Retrieval Impairment

Category of Overuse	Characteristic Lang.	Sample Student Talk
Stereotyped phrases	watcha'ma call it, you know	I went to the watcha' ma call it store for it.
Words lacking in specificity	thing, deal, junk, stuff	I like that stuff but she thinks it's junk.
Imprecise and restrictive verb use	got, do, make/made, put	I got the fish. (caught) I put the seed in. (planted)
Indefinites	this, that, something, solo pronouns	I went somewhere to buy something delicious.
Semantically empty place holders	uh, uhm, ah, err, well	I uh.. went somewhere...ah to, well...buy it.
Circumlocution	descriptions rather than specific labels	I went to the place that wild animals live.
Prolonged pauses	pause	I went to (pause) the place that (pause) wild animals live.
Dysfluency	word/phrase repetition & sentence revisions	I went to, I went to the place that..that..I went to that wild place.
Starters	and then, now, well, so (used to begin sentences)	And then I went to the zoo and I saw him and so we fed er em.
Borrowed word formations	invented or extended word use	I got volcano craters all (chicken pox)
Perserverative repetitions	repetitions as expansions	I'm going to have cream, ice cream, vanilla ice cream.
Mispronunciations	Sound-alike words	The baby is topsy turbie; I'm flusterated.
Prefix or suffix substitution	un/dis	He's unsatisfied with me.

Analyze: Teachers can also identify children with word retrieval impairments through their performance profiles. These students exhibit low scores on tests for listening comprehension, similarities, vocabulary, digit span and general language arts skills. They almost always demonstrate a significant difference between verbal and performance scores on intellectual assessment. Classroom grades most often reflect weakness in Reading, Science, History and Social Studies.

Teach/Compensate: Memory deficits can be strengthened through teaching the student to use a set of rules for improving auditory attention (when someone is speaking — watch the person, sit quietly, focus on what is being said and try to make sense of it, no talking). Mnemonic strategies are extremely helpful in increasing memory for unrelated information. Preferential seating (allowing the child to sit close to the speaker) will improve accuracy of auditory input. The teacher should use concrete, meaningful visual examples as often as possible and speak slowly and clearly.

Semantic organization can be encouraged in the classroom through the use of webbing/mapping and concrete visual cues. New vocabulary should be taught in units or classes. Cognitive compensations can be used to form associations between verbal information so that it can more readily be retrieved. The Appendix lists each of the cognitive areas needed to be incorporated when teaching new vocabulary. Connections between words also can be strengthened by teaching opposites, similarities, differences, analogies and associations. Encourage students to connect the new material to what they already know. Learning synonyms and allowing additional time for retrieval are both excellent compensatory techniques to strengthen word retrieval.

Practicing weak skills can be implemented during enjoyable extracurricular or reinforcement activities. Resources can also be provided to parents for purchasing more appropriate games. More ideas can be provided by the school speech and language clinician.

Resources

Bloom, Benjamin S. (Ed.). (1956). *Taxonomy of educational objectives: The classification of educational goals. Handbook I: Cognitive domain.* New York: David McKay Co.

Carey, R., Levin, M. & Levin, J. (1993). Mnemonic strategies: Instructional techniques worth remembering. *Teaching Exceptional Children.* Summer issue.

Cooper, P. (1985). *Activities for teaching speaking and listening, grades 7-12.* ERIC.

Wolf Nelson, N. (1993). *Childhood language disorders in context: Infancy through adolescence.* New York, NY: Macmillan Publishing Co.

Commercial games/toys

Guess Who
Scattergories Jr.
Outburst Jr.
Riddle Race
Pictionary Jr.
Tongue Twisters (Ravensburger Press)
Tabu
Balderdash
Goosebumps flashcards
Password
The Word Game (Ravensburger Press)

Thanks to Anna H. Costarides, Ph.D. (University of South Alabama) for her review and suggestions for this handout.

Appendix

Make Every Lesson Bloom

1. **Knowledge** — Student recalls basic facts and information
   Ex: who, what, where, when, which, how many, why, name, locate, define, recall

2. **Comprehension** — Student grasps the meaning of information & explains it in his/her own words
   Ex: explain, match, describe, tell in your own words, tell the main idea, rewrite, illustrate, compare, give an example

3. **Application**-- Student will use learned knowledge in new & concrete situations
   Ex: Show, sort, what else, name some other, did this ever happen to you? what's wrong with? solve this problem, summarize, apply, think of a synonym for

4. **Analysis** — Student will take a situation apart to examine or work with the different parts
   Ex: why, how are they alike, how are they different, what are the causes, what are the solutions, what are the steps, which one comes first/last, opposite, complete this analogy, analyze

5. **Synthesis** — Student will use all previous levels of thinking to form new and/or creative ideas
   Ex: create, design, predict, think of all the ways, how else, how can you improve, compose, draw, suppose, what would it be like if, compose a definition

6. **Evaluation** — Student will be able to judge value of information and justify his/her answers
   Ex: judge, choose, which do you like? which is best? recommend, evaluate, decide which, will it work? rate from good to poor, select the best meaning of

— *Modification of information from Benjamin S. Bloom* (see resources)

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Written Expression

Teaching Children to Write Well

by Ruben Lopez
Moreno Valley (CA) Unified School District

Introduction

Writing is invaluable *to learn and for learning* other subjects. Children who make steady progress in learning to write are likely to find success in school from the first grade through college. However, learning to write well is not easy. To learn to write, a child needs frequent opportunities, encouragement and direct teaching from parents and teachers.

A child will value writing when given the opportunity to learn that writing is *meaningful and useful.* The value of writing extends beyond school and job success. Writing allows a child to send his or her thoughts over long distances as in a letter to a beloved relative or in a conversation over the Internet. Writing creates a record of a child's thoughts that will last as long as does the material on which it is placed. Writing allows a child to describe a cherished experience, to argue a point of view, to learn about a subject, to express feelings and affections, and to create new worlds, beings and ideas.

Early Development

Oral language is writing's foundation. Educators often call writing "written expression." Written expression is a complex skill made up of other skills (subskills). Its foundational skill is a child's oral language, the language used in conversation. The writing a student produces will reflect his or her knowledge and use of word meanings (vocabulary), word order (grammar) and social use of language (knowledge about interacting with another person — a reader or an audience — readers). Problems with oral language are likely to hinder development in writing.

Knowledge and experiences are required for content and motivation in writing. In addition to various oral language skills, writing requires knowledge and experiences for content (what a student writes about). Providing children with positive experiences will help motivate them to write. A parent asking a child about an experience helps the child to develop the essential writing-related skill of story-telling. A teacher can help a child transfer the skill of oral story-telling to story writing by handwriting or typing a story a child says to the teacher.

Good writing is story-telling. Since the fundamental nature of writing is story-telling, it is not surprising that the oral story-telling a child practices will serve as an important preliminary step to writing. As in a good story, writing that clearly states and links characters and actions (verbs) will be easily understood by and interesting to a reader. Even when writing about the social or natural sciences, students will produce understandable writing if they tell stories with specific characters and actions.

Development in School

Skills in reading, spelling, and handwriting are necessary for writing. Growth in reading, spelling, and handwriting directly influence a student's growth in writing. A student who struggles with spelling or handwriting every other word, for example, will not likely to be effective in presenting his or her thoughts logically or thoroughly. Learning to write should also include explicit instruction in grammar and punctuation. Even for those with suspected learning disabilities, learning to write requires learning the other basic skills. However, computers to print and correct spelling should be used at times to allow a child to focus on writing itself.

Important Ideas for Teaching Writing

Communication with a reader(s), not the subskills, is the aim of writing. Although fluency (accuracy and speed) in skills supporting writing is essential, when writing is the target, emphasis should not be placed on writing subskills. Emphasis on writing subskills, such as spelling, grammar or handwriting, can in fact discourage a child from writing. From preschool to college, teachers and parents need to make clear that the goal of writing is to communicate with a reader (if only the classroom teacher or college professor). Writing as communication signifies the importance of a writer constantly considering if the reader will understand and find interesting what is being written. Also, it conveys that the form of writing (for example, whether or not a student's work is in a pretty plastic cover) is less important than its meaning.

Process writing: Writing is a process with revision as the central activity. Teachers refer to writing processes as process writing. What they mean is that good writing requires several steps. The writing process involves planning and organizing what is going to be written, writing a draft, revising it with the reader in mind and then editing the final draft. The important message of this view of writing is that writing does not have to be perfect the first time. This lets students feel free to express themselves.

Text structures are valuable tools for writing. Text structures are specific formats for organizing writing for specific purposes and types of writing. Some writing programs, for example, teach book report writing. They present the parts of a good book report and how to organize the parts. Other valuable text structures are for writing stories, explanations and persuasive pieces. The idea of teaching text structures and the writing process is to give students expert strategies for writing. The use of expert writing strategies establishes a foundation for creativity.

Parents and teachers ensure success: A parent's watchful eye and encouragement and the direct and specific teaching of many teachers are needed to ensure success in learning to write. Although writing is a natural expression of being educated, it should not be thought of as a skill that will be learned without watchful and active parents and teachers. Furthermore, parents and teachers should rely on well-designed and tested programs and materials for helping students to learn to write well.

Resources

Berninger, V. W., & Hooper, S. R. (Eds.). (1993). Preventing and remediating writing disabilities: Interdisciplinary frameworks for assessment, consultation, and intervention [Mini-series]. *School Psychology Review, 22*, 590-686. Presents a research-based and practical overview of writing education.

Bradley-Johnson, S. & Lesiak, J. (1989). *Problems in written expression: Assessment and remediation.* New York: Guilford Press. Examines a variety of approaches to evaluating and remediating writing problems. Includes reviews of tests of writing skills.

Graham, S., & Harris, K. R. (1997). It can be taught, but it does not develop naturally: Myths and realities in writing instruction. *School Psychology Review, 26*, 414-424. Challenges unsupported views of writing instruction.

Heward, W. L., Heron, T. E., Gardner III, R., & Prayzer, R. (1991). Two strategies for improving students' writing skills. In G. Stoner, M. R. Shinn, & H. M. Walker (Eds.), *Interventions for achievement and behavior problems* (pp. 379-398). Silver Spring, MD: National Association of School Psychologists. Thoroughly describes systematic activities for teaching writing.

Stein, M., Dixon, R. C., & Isaacson, S. (1994). Effective writing instruction for diverse learners. *School Psychology Review, 23*, 392-405. Concisely describes the elements and "big ideas" of effective writing instruction.

Williams, J. M. (1990). *Style: Toward clarity and grace.* Chicago: University of Chicago Press. Provides specific guidance on non-fiction writing based on findings about "what readers look for" and the idea that good writing is story-telling.

Zinsser. W. (1988). *Writing to learn.* New York: Harper & Row. Explains how writing is important for learning new subjects.

NATIONAL
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PSYCHOLOGISTS

Anxiety in Children

Information for Parents

Social and Emotional Development

by Thomas J. Huberty, Ph.D.
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Background

Anxiety is a universal experience and can be part of normal development in children. There appears to be no significant differences across social class, ethnic groups or gender in the experience of anxiety. However, boys and girls may be anxious about different things, e.g., social approval for girls and peer relationships for boys. Anxiety ranges from being alert to possible danger to a state of impaired functioning. The central characteristic of anxiety is that the child is afraid about an event that has a real or an imagined threat. It doesn't matter whether the fear is based on a real situation; if the child believes a threat exists, anxiety will occur. Consequently, any situation has the potential to produce anxiety.

Development

It is important to remember that children normally experience and show anxiety in many ways as they develop. Worry, poor concentration, poor memory, poor attention, poor problem solving, over sensitivity, restlessness, nervousness, withdrawal, erratic or irrational behavior, running away, aches and pains, bed wetting, nausea, vomiting, perspiration, tension or a rapid heart rate all can be symptoms of anxiety.

Anxiety from infancy to adolescence: Babies experience developmentally appropriate stranger anxiety at about seven to nine months of age, usually ending by age one year. Early in the second year of life, children begin to experience separation anxiety — distress over separation from caretakers — which lasts about a year. During the preschool years, children's anxiety turns to specific objects and events (e.g., large dogs, separation from parents). As the child matures, the number of fears remains about the same, but will vary in complexity and type. As the child grows there is also a gradual change from global, undifferentiated and externalized fears to more distinct, abstract and internalized worrying. As adolescence approaches, anxiety about more social and personal issues develop into concerns about moral, religious and sexual issues.

Characteristics: The most significant characteristic of anxiety is worry. For worry to happen the child's reasoning must be sufficiently developed so that he can anticipate future events and engage in repetitive thoughts about possible threatening circumstances. At preschool and early childhood, children tend to be limited in their ability to engage in such anticipatory thinking, but, by middle childhood, these skills have begun to emerge and are very evident at adolescence. If the child is able to be consistently concerned about a possible future negative event (i.e., worry) but feels that there is no hope of preventing it, then the child may develop high levels of anxiety that interfere with normal functioning. Although severe anxiety disorders, (e.g., post-traumatic stress disorder, separation anxiety disorder, generalized anxiety disorder) have a relatively low incidence (2.5% to 10%) in children, when present they must be addressed. Also, when present, severe anxiety disorders in children often accompany other disorders, such as depression and conduct disorder.

Children with high levels of anxiety may show cognitive deficiencies or cognitive distortions, which can have significant impact on problem-solving skills. Cognitive deficiencies are the absence of information processing skills needed to successfully cope with a real or perceived threat. Cognitive distortions happen when a child misconstrues or misperceives events. Although reasoning is present, it may be irrational, illogical or distorted from real or probable events. Children with high levels of anxiety feel unable to control their environment and behavior.

A common problem in school settings is "test" or "performance" anxiety, when students become anxious about taking a test or performing to the extent that performance is affected negatively. This type of anxiety occurs as the result of fear of failure, feeling embarrassed, or being convinced that poor performance is almost certain. Some children are more anxious than others and may be overwhelmed during activities requiring good performance.

What Can I Do as a Parent?

Remember that anxiety is a normal aspect of everyday living, which can make it difficult to know when it has become a problem requiring intervention. The following questions may be used as guides to determining the nature and extent of its impact:

- Is the anxiety typical for a child of this age?
- Is the anxiety shown in rather specific situations or is it pervasive?
- Is the anxiety long-term or of recent origin?
- What events may be contributing to the child's anxiety?
- How is the anxiety affecting personal, social or school functioning?

Warning signs: When should a parent be concerned that a child's anxiety is out of the ordinary? You should seek help for your child if you notice:

- Morbid fears of accidents or illnesses affecting himself or important others.
- Constant seeking of reassurance about school performance, friendships, upcoming events.
- Frequently seeking to stay home from school.
- Worrying incessantly about appearance, clothing, behavior, possessions, future events.
- Frequent physical symptoms related to anxiety, such as sweating, nausea, excessive talking, pacing, trembling.
- Sleep difficulties (especially in younger children).
- Clinging to parents in public (among older children).

The first step in helping the anxious child is to understand the nature of the problem. Review the questions and warning signs above to gain a perspective on the severity of the problem. It may be necessary to work with a school psychologist or other mental health professional to identify the components of anxiety that are affecting your child. The following guidelines may be useful in helping to maintain anxiety at a reasonable level:

- Be consistent in handling your child and administering discipline.
- Set and maintain realistic, attainable goals and expectations for your child.
- Maintain a consistent routine regarding homework, chores, activities, etc.
- *Listen and talk* to your child when she or he reports feeling worried or tense about an upcoming or imagined event. Do not treat these feeling as "silly" or unimportant, because they *are* important to the child. Listen with interest and concern, and give advice only when asked.
- Do not assume the child is being difficult, or that the problem will just "go away". There is evidence that some anxiety problems can persist into adulthood. Therefore, early identification and intervention can be very important.

Treatment of anxiety: Anxiety problems can be treated very effectively, returning the child to a normal level of anxiety for his age group. Individual or family counseling may be necessary to clearly identify the problem, which then can be followed by appropriate intervention. Specific behavioral interventions can help children learn to change their perceptions, monitor their level of distress, relax to reduce stress, etc. Children can also learn to improve skills in specific areas that seem related to their anxiety — social skills, study skills, organization skills, anger management, etc. In cases of extreme anxiety that seems resistant to intervention, medication might be recommended. Because other problems can co-exist with anxiety (such as depression), unrelenting symptoms that significantly interfere with your child's life and happiness should be evaluated by a mental health professional. Consult with your school psychologist if anxiety seems to be a significant problem for your child.

Resources

Feiner, J. (1988). *Taming monsters, slaying dragons: The revolutionary family approach to overcoming childhood fears and anxieties.* New York: Arbor House.

Martin, M. & Waltman-Greenwood, C. (1995). *Solve your child's school-related problems.* New York: HarperPerenniel.

Mendler, A. (1990). *Smiling at yourself: Educating young children about stress and self-esteem.* Santa Cruz, CA: Network Publications. (For children under age 10)

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Attachment

A Handout for Parents

by Amy Sussam-Stillman, Ph.D.
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What Is Attachment? Why Is It Important?

Attachment is a term used to describe the emotional connection between infants and their parents. Attachment is not the same as bonding. Bonding refers to a short-term phenomenon that occurs shortly after birth and describes the parents' experiences of getting to know and to feel close to their new baby. Attachment, on the other hand, is a relationship that develops over a longer period of time and depends upon both partners, the parent and the child. It describes the quality of the relationship between the parent and the child.

The quality of the relationship between parents and children is an important factor in helping children develop into competent, happy, productive adults. It is through warm, caring and trusting relationships between parents and children that children learn life-long social, emotional and cognitive skills. When children feel safe and secure in the world, they explore the world more fully, try new things, make mistakes, build meaningful relationships with other children and adults, and view the world in a positive light. A large body of research shows that a relationship with a supportive, caring adult helps children successfully overcome life's adversities and challenges.

How Do Children Form Attachments to Their Parents?

Nearly all children form attachments to their parents. The attachments are usually well-established by the end of the first year of the child's life and continue throughout life. However, those attachments, or relationships, are not all the same. Attachments can be grouped into two categories: secure and insecure.

Why are some children securely attached and others insecurely attached? The quality of the attachment is largely determined by how parents care for their babies. Babies are *securely attached* when their parents are consistently sensitive and responsive to their needs. Their parents consistently comfort them when they cry or are upset, and play with them in age-appropriate ways. These babies trust that they can get support and care from adults, and think the world is a safe place.

When parents are inconsistent or unresponsive to babies' needs, babies do not think of the world as a place of comfort, and get a message that their needs are unimportant. In essence, they learn that they cannot rely upon parents for care and support. These earliest messages lay the foundation for children's later development.

Does It Matter If Children Have Secure or Insecure Attachments?

Yes. The quality of attachment is related to different patterns of behavior and long-term effects. Children who are securely attached explore their environments more thoroughly and enthusiastically, have more tolerance for challenging situations, are better liked by teachers and students, and are better at problem-solving and showing empathy.

Children who are insecure may manifest their anxiety in one of two patterns: avoidance or resistance. *Avoidantly attached* children often develop behavior problems (including aggressive or socially withdrawn behavior), are unpopular with other children, lack motivation and persistence in learning, and tend to be victimizers of other children. *Resistantly attached* children tend to be overly dependent upon teachers for help and attention, lacking in confidence and self-esteem, less able to form friendships than other children, socially withdrawn from peers, and the victims of more aggressive peers.

What Can Parents Do to Form Secure Attachments?

Parents can do a lot to form secure attachments with their babies. The key is responding sensitively and consistently, taking the cues from your baby. You can think of it like slow dancing, with you, the parent, letting the baby lead and following her steps. You can encourage secure attachment by: .

- holding and caressing your baby
- comforting your baby when she cries
- speaking to your baby warmly
- establishing eye contact and smiling at your baby
- playing baby games, such as peek-a-boo or this little piggy
- creating and maintaining a stable environment and routine for your baby
- enjoying your baby and her unique self!

Taking care of a baby can be very difficult and challenging for parents. Parents are best able to meet the needs of their babies when:

- their basic needs have been met (food, clothing, shelter, emotional support)
- they have knowledge about child development and understand the meaning of key behaviors (e.g., separation anxiety); and
- they examine their own childhood experiences and how those influence their current parenting behaviors and attitudes.

If you are stressed or having other personal difficulties, you may want to seek help or support from a family member, friend, or professional. To take care of a baby, you also need to take care of yourself.

Where to Go for Help

There are professionals who can help you if you are concerned about the quality of your relationship with your baby or with your baby's development. Call:

- local school district's school psychologist
- local mental health association
- crisis hotline
- parent support groups, such as Parents Anonymous

Resources

Brazelton, T. B. (1992). *Touchpoints: The essential reference.* New York: Addison-Wesley.

Erickson, M.F. & Glenn, L. (1997). *Child-adult attachments.* St. Paul, MN: University of Minnesota, Children, Youth and Family Consortium.

Karen, Robert. (1998). *Becoming attached: The charachter of parental love and its legacy in later life.* Oxford University Press.

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Dependency

A Handout for Parents

by Chuck McBride and Max McFarland, Ed.D.
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Revised by Stella Thompson, Collegedale, TN

Background

Dependency in children is a problem often ignored because excessive dependence seems to pose less serious problems than aggression and noncompliance. However, dependency can interfere with the development of the skills and confidence necessary for decision-making. Social development can also be delayed by dependency, causing children problems in their relationships with adults and other children.

Development

Depending on others for needs, such as food and transportation, is normal as a child grows from infancy to adulthood. Dependency becomes a concern when the child becomes reliant on others for making decisions or for self-help skills, such as reading or personal care. Dependency is encouraged by:

- overprotectiveness — too much supervision of a child's play
- interference with independent decision-making such as choosing the child's clothing in order to coordinate colors
- removing responsibility, such as always cleaning the child's room and making the bed
- interference with social development, such as choosing the child's friends and activities
- interference with problem-solving, such as interceding in arguments or difficulties rather than allowing the child to find solutions

Parental guilt can also cause dependency in a child. Busy parents may feel guilty about not spending more time with their child, and parents of an ill or injured child often feel the need to compensate for the child's illness. These overcompensations lead to doing unnecessary things for the child. Manipulation may be practiced by ill or injured children or by children who find some task difficult. The seeming helplessness of these children sometimes causes adults to complete the task or to remove the responsibility, hindering the child's development of self-reliance. The parent's good intentions rob the child of confidence in his or her own skills.

Characteristics

Dependent children lack enthusiasm. They do not set goals because they feel helpless to control their circumstances. They do not feel that their studying will help them to pass a test. They expect to fail at any new activity, and they are afraid to meet new people. They prefer the safety of not risking failure, so they rely more and more on others to do things for them.

Dependency varies with the situation and the child. A child may be more dependent in the presence of one parent or teacher than with another. Behaviors which might indicate dependency include:

- Clinging to adults
- Expecting to fail, won't try tasks alone

- Immaturity
- Being indecisive
- Preferring younger play partners
- Lacking self-respect
- Withdrawing
- Lacking confidence, constantly seeks approval
- Difficulty maintaining relationships with peers
- Fear of making a mistake
- Avoiding new activities
- Depression

How Can I Help?

Helping a child with dependency can mean breaking familiar habits. It may mean giving the child more freedom and being less protective in order to prevent smothering the development of independence.

Health and illness: Care for health needs, but allow the ill or injured child to do what he or she is capable of doing. Pampering is unnecessary. Expectations should reflect the child's abilities under the new circumstance. For example, broken arm does not prevent a child from completing tasks related to walking or talking.

Encourage independence: A child's attempts to manipulate people or situations should be promptly managed or ignored, while praise and encouragement should promptly be given for any attempt made to complete tasks independently. Give the child opportunities to try new things and to meet new people. Let the dependent child know that you are proud of his or her willingness to take these risks. A hug and a word of encouragement may prompt new efforts.

Success will encourage independent effort while failure will encourage dependence. Provide opportunities for the child to grow in areas that require familiar skills before venturing into more difficult or less familiar areas.

Establish consistency: To avoid confusion, rules should be clear to all who are involved with the child. Open communication and clear boundaries will help the child to develop confidence in decision making. Consistency, routine, and follow-through are important to a dependent child. A consistent plan of action helps the child to develop self-reliance.

Encourage decision-making and problem solving: Begin giving the child freedom to choose between two acceptable choices. Independent decision-making can be developed through these safe choices. Fear of criticism or failure is removed when both choices are acceptable. Gradually extend the choices as the child becomes more confident.

Problem solving is learned by solving problems. Interceding for a child hinders this process. Allow the child to confront all reasonable conflict using his or her own growing resources.

Encourage self-reliance: Teaching a child to clean a room, to make a bed, to fold or hand clothes requires time and effort; however, these responsibilities produce confidence and independence. The dependent child should be praised for efforts made and for the process of completing the task rather than for the final result only. Gear expectations to the child's age and level of development.

Nurture self confidence: Independence is developed one step at a time by patient support and praise. Gradually increase the child's independence and responsibility by praising each new effort and encouraging independent decision-making. Let the child know that you care. Your interest in his or her activities, conversation, and opinions will encourage new efforts. Your confidence in the child's abilities will eventually nurture self-confidence and independence in the reluctant child.

Seek support from other parents: A support group of parents who share ideas and strategies can make dealing with a child's dependency easier.

Resources

Clemes, H. & Bean, R. (1990). *How to teach children responsibility.* New York: Putnam.

Martin, M. & Waltman-Greenwood, C. (1995). *Solve your child's school-related problems.* New York: HarperPerenniel.

Rich, D. (1992). *Megaskills.* New York: Houghton-Mifflin.

The original version of this handout was published in "Helping Children Grow Up in the 90s" *by the National Association of School Psychologists in 1992 and revised by Stella Thompson in 1997.*

NATIONAL
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Depression in Children

A Handout for Parents

**by D.H. Saklofske, Ph.D., University of Saskatchewan,
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Background

Depressed mood is a common and universal part of human experience. It can occur at any age and have many causes. Children can report or display feelings of unhappiness, sadness, dejection or irritability, but most children recover quickly from these brief and normal moods or emotional states. For others, however, depression can be severe and long-lasting, and can interfere with all aspects of daily life ranging from achievement in school to family relationships.

The incidence of severe depression in children is probably about 5 to 6 %, although exact figures are not known. While there are no gender differences in the diagnosis of mood disorders in childhood, girls are more likely than boys to be diagnosed with depression during adolescence and adulthood. Depression and the associated risk of suicide increase significantly during adolescence.

Diagnosing and Treating Childhood Depression

The onset of depression can be gradual or sudden, brief or long-term. Because depression may co-exist with other disorders such as anxiety and Attention Deficit Disorder, recognizing and diagnosing childhood depression can be difficult. Although a child may exhibit one or two symptoms of depression, the presence of a major depressive disorder is generally considered only if four or more symptoms are observed over an extended period of time. Depressive features vary in relation to the age and developmental level of the child. For example, physical complaints, agitation, anxiety and fears are more often seen in younger children. Adolescents, on the other hand, are more likely to display antisocial and argumentative behavior, and exhibit restlessness and irritability.

Types of Depression: Depression is usually diagnosed by a psychologist or psychiatrist using criteria from the *Diagnostic and Statistical Manual of Mental Disorders — Fourth Edition,* published by the American Psychiatric Association (1994). The severity of depression is usually classified as mild, moderate or severe. The duration of depressed mood is a key element in helping determine the severity and type of depression. Normal sadness is usually short lived. Children have mood swings, like adults, and a certain amount of sadness is a natural part of life. If the sadness comes and goes within a matter of a few days, there is probably nothing to be concerned about. A long term, mild type of depression is sometimes called *Dysthymia*. Another less severe form is an *Adjustment Disorder* with depressed mood caused by some known stressor and lasting less than six months.

When depression is severe, it interferes significantly with life activities (e.g. school, social life, family relations, etc.). *Major depression* is diagnosed if the child exhibits depressed or irritable mood and/or loss of interest or pleasure in almost all activities for a period of at least two weeks. Severe depression can sometimes lead to suicide attempts. Suicide attempts are uncommon in early childhood, but become possible in later childhood and more common in severely depressed adolescents. If you are concerned that a child or adolescent may be suicidal, keep him or her supervised and seek professional help immediately.

Causes: A number of causes have been suggested regarding childhood depression. Biological explanations of depression include the roles of hereditary, biochemical, hormonal and neurological factors. More recently, the amount of light associated with seasonal changes has been thought to affect mood ("seasonal affective disorder").

Psychological explanations have linked depression to the loss of loved ones, disturbances in child-parent relationships and threats to self-esteem. Attention has also been focussed on the way children interpret and structure everyday experiences and the belief they have about their ability to control and shape their world. Any number of psychological stressors may significantly affect the mood of some children.

Treatment: Given the various kinds and causes of childhood depression, different treatments may be required. On the one hand, feelings of failure and irritability caused by a poor school grade could simply signal the need to improve study habits and pay closer attention in school. Alternatively, when the signs and symptoms of depression are persistent and more severe, the professional assistance of a psychologist or psychiatrist should be sought. Antidepressant and anti-anxiety medications are beneficial in the treatment of severe depression. Several effective forms of psychological treatment include behavioral and cognitive-behavioral therapies. Combined medication and psychotherapy programs are frequently employed in the treatment of depression.

Symptoms of Depression in Children

Be aware of common symptoms: The symptoms of depression vary based both on the individual personality of the child and on the child's developmental stage. Be aware that many of the symptoms listed are also characteristic of other types of problems (see section below on "How do I know what it's not?"). If some of these symptoms are present, you will want to consider seeking a professional diagnosis:

Depressed or irritable mood
Loss of interest or pleasure
Social withdrawal
Agitation
Misbehavior or discipline problems
Low self-esteem
Feelings of worthlessness
Feelings of hopelessness
Difficulty concentrating

Frequent crying
Physical complaints
Change in body weight
Lack of appropriate weight gain/growth
Change in appetite
Difficulty or excessive sleeping
Fatigue
Self injurious behavior
Discussion of or suicidal attempt

How do I know what it's **not?** Many of the symptoms listed above are also symptoms of other problems or disorders. For example, fatigue could be caused by a simple lack of sleep, a sleep disorder, drug or alcohol use, the flu, or many other underlying problems. None of the symptoms individually or even taken in clusters are unique to depression in children.

The following are some problems that can be difficult to differentiate from depression because they have some symptoms in common. Some of the primary symptoms they share in common are also listed. This is certainly not an exhaustive list and an appropriate mental health professional will be able to rule out these and other causes for the symptoms presented.

Condition	Primary Symptoms in Common with Depression
Anxiety	Agitation, physical symptoms
Conduct Disorder	Misbehavior or discipline problems ("acting out behavior")
Attention Deficit Disorder	Difficulty concentrating, poor academic performance, low self-esteem
Learning Problems/Disabilities	Poor academic performance, difficulty concentrating, low self-esteem
School Phobia	Physical complaints, agitation, poor academic performance
Social Skills Deficits	Social withdrawal, misbehavior or discipline problems
Physical Illness	Physical complaints, change in appetite, fatigue
Eating Disorders	Change in body weight, lack of appropriate weight gain/ growth, change in appetite, low self-esteem

What Can Parents Do to Help?

The following list of suggestions addresses the most frequently cited symptoms of childhood depression:

1. ***Self-esteem and self-critical tendencies:*** Give frequent and genuine praise; accentuate the positive; supportively challenge self-criticism and point out negative thinking.
2. ***Self-blame and guilt:*** Help the child distinguish between events that he/she can control from those that are uncontrollable; facilitate positive self-talk; encourage restitution if appropriate.
3. ***Family stability:*** Maintain routine and minimize changes in family matters; discuss changes beforehand and reduce worry.
4. ***Helplessness and hopelessness:*** Ask the child to write or tell current feelings and record pleasant thoughts 3 to 4 times a day in order to increase pleasant thoughts over a period of 4 to 6 weeks.
5. ***Loss of interest and "blue" mood:*** Arrange an interesting activity per day; plan for future special events; discuss enjoyable topics.
6. ***Appetite and weight problems:*** Don't force eating; prepare favorite foods; make meal-time a pleasant occasion.
7. ***Sleep difficulties:*** Keep regular bed-time hours; do relaxing and calming activities one hour before bed-time such as reading or listening to soft music; end the day on a positive note.
8. ***Agitation and restlessness:*** Change activities causing agitation; teach the child relaxation techniques; massage may help; encourage physical exercise and recreation activities.
9. ***Excessive fears:*** Minimize anxiety-causing situations and uncertainty; be supportive and reassuring; planning may reduce uncertainty.
10. ***Aggressive behavior and anger:*** Convey a kind but firm unacceptance of destructive behavior; validate the emotion and encourage the child to express his/her angry feelings appropriately; do not react in anger; be consistent with your responses to inappropriate behavior.

11. ***Concentration and thinking difficulties:*** Encourage increased participation in games, activities, family discussions; work with the teachers and school psychologist to promote learning.
12. ***Suicidal thoughts:*** Be aware of the warning signs of suicide; seek professional help immediately.
13. ***If depression persists:*** Consult your family doctor for a complete medical exam; seek a referral to a school psychologist, clinical psychologist or psychiatrist.

Resources

Ingersoll, B.D. & Goldstein, S. (1995). *Lonely, sad, and angry: A parent's guide to depression in children and adolescents.* New York: Doubleday.

Martin, M. & Waltman-Greenwood, C. (Eds.) (1995). *Solve your child's school-related problems.* New York: HarperPerenniel.

Mendler, A.N. (1991). *Smiling at yourself: Educating young children about stress and self-esteem.* Santa Cruz, CA: ETR Associates.

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Depression in Children

A Handout for Teachers

**by D.H. Saklofske, Ph.D., University of Saskatchewan,
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The incidence of severe depression in children is probably about 5 to 6 %, although exact figures are not known. While there are no gender differences in the diagnosis of mood disorders in childhood, girls are more likely than boys to be diagnosed with depression during adolescence and adulthood. Depression and the associated risk of suicide increase significantly during adolescence.

Diagnosing and Treating Childhood Depression

The onset of depression can be gradual or sudden, brief or long-term. Because depression may co- exist with other disorders such as anxiety and Attention Deficit Disorder, recognizing and diagnosing childhood depression can be difficult. Although a child may exhibit one or two symptoms of depression, the presence of a major depressive disorder is generally considered only if four or more symptoms are observed over an extended period of time. Depressive features vary in relation to the age and developmental level of the child. For example, physical complaints, agitation, anxiety and fears are more often seen in younger children. Adolescents, on the other hand, are more likely to display antisocial and argumentative behavior, and exhibit restlessness and irritability.

Types of Depression: Depression is usually diagnosed by a psychologist or psychiatrist using criteria from the *Diagnostic and Statistical Manual of Mental Disorders — Fourth Edition*, published by the American Psychiatric Association (1994). The severity of depression is usually classified as mild, moderate or severe. The duration of depressed mood is a key element in helping determine the severity and type of depression. Normal sadness is usually short lived. Children have mood swings, like adults, and a certain amount of sadness is a natural part of life. If the sadness comes and goes within a matter of a few days, there is probably nothing to be concerned about. A long term, mild type of depression is sometimes called *Dysthymia*. Another less severe form is an *Adjustment Disorder* with depressed mood caused by some known stressor and lasting less than six months.

When depression is severe, it interferes significantly with life activities (e.g. school, social life, family relations, etc.). *Major depression* is diagnosed if the child exhibits depressed or irritable mood and/or loss of interest or pleasure in almost all activities for a period of at least two weeks. Severe depression can sometimes lead to suicide attempts. Suicide attempts are uncommon in early childhood, but become possible in later childhood and more common in severely depressed adolescents. If you are concerned that a child or adolescent may be suicidal, keep him or her supervised and seek professional help immediately.

Causes: A number of causes have been suggested regarding childhood depression. Biological explanations of depression include the roles of hereditary, biochemical, hormonal and neurological factors. More recently, the amount of light associated with seasonal changes has been thought to affect mood ("seasonal affective disorder").

Psychological explanations have linked depression to the loss of loved ones, disturbances in child-parent relationships and threats to self-esteem. Attention has also been focussed on the way children interpret and structure everyday experiences and the belief they have about their ability to control and shape their world. Any number of psychological stressors may significantly affect the mood of some children.

Treatment: Given the various kinds and causes of childhood depression, different treatments may be required. On the one hand, feelings of failure and irritability caused by a poor school grade could simply signal the need to improve study habits and pay closer attention in school. Alternatively, when the signs and symptoms of depression are persistent and more severe, the professional assistance of a psychologist or psychiatrist should be sought. Antidepressant and anti-anxiety medications are beneficial in the treatment of severe depression. Several effective forms of psychological treatment include behavioral and cognitive-behavioral therapies. Combined medication and psychotherapy programs are frequently employed in the treatment of depression.

Symptoms of Depression in Children

Be aware of common symptoms: The symptoms of depression vary based both on the individual personality of the child and on the child's developmental stage. Be aware that many of the symptoms listed are also characteristic of other types of problems (see section below on "How do I know what it's not?"). If some of these symptoms are present, you will want to consider seeking a professional diagnosis:

Depressed or irritable mood
Loss of interest or pleasure
Social withdrawal
Agitation
Misbehavior or discipline problems
Low self-esteem
Feelings of worthlessness
Feelings of hopelessness
Difficulty concentrating

Frequent crying
Physical complaints
Change in body weight
Lack of appropriate weight gain/growth
Change in appetite
Difficulty or excessive sleeping
Fatigue
Self injurious behavior
Discussion of or suicidal attempt

***How do I know what it's* not?** Many of the symptoms listed above are also symptoms of other problems or disorders. For example, fatigue could be caused by a simple lack of sleep, a sleep disorder, drug or alcohol use, the flu, or many other underlying problems. None of the symptoms individually or even taken in clusters are unique to depression in children.

The following are some problems that can be difficult to differentiate from depression because they have some symptoms in common. Some of the primary symptoms they share in common are also listed. This is certainly not an exhaustive list and an appropriate mental health professional will be able to rule out these and other causes for the symptoms presented.

Condition	Primary Symptoms in Common with Depression
Anxiety	Agitation, physical symptoms
Conduct Disorder	Misbehavior or discipline problems ("acting out behavior")
Attention Deficit Disorder	Difficulty concentrating, poor academic performance, low self-esteem
Learning Problems/Disabilities	Poor academic performance, difficulty concentrating, low self-esteem
School Phobia	Physical complaints, agitation, poor academic performance
Social Skills Deficits	Social withdrawal, misbehavior or discipline problems
Physical Illness	Physical complaints, change in appetite, fatigue
Eating Disorders growth, change	Change in body weight, lack of appropriate weight gain/ in appetite, low self-esteem

What Can Teachers Do to Help?

If you suspect a student is depressed, it is important to talk (and listen!) to the student, other school personnel and parents about your concerns. Are there situational stressors that might explain the student's behavior and affect? Are others aware of changes in behavior, performance, energy level, etc? It is also important to observe the student in various settings — in the classroom, cafeteria, playground, etc. Be aware of themes of sadness, anger or death in writing and artwork. Review the student's records — are there patterns of a downward trend in performance, change in attendance, health concerns? Some other strategies for working with students who display symptoms of depression:

- Consult regularly with parents, school psychologist, health professional, counselor regarding your concerns, monitor symptoms and coordinate support and referral efforts
- Seat student near friends or potential friends. Avoid situations that might socially isolate or ostracize the student (such as allowing students to choose teams for games or group projects)
- Give student advance warning and preparation time for any change in school/classroom routine
- Work with student to set attainable academic goals
- Utilize active learning approaches with hands-on activities of high interest whenever possible
- Give frequent and genuine praise
- Help student focus on positives, minimize negative thoughts and self-criticism
- Provide choices when appropriate
- Establish clear and consistent classroom rules and consequences
- Be alert to suicidal thoughts and behaviors; take suicidal threats seriously with continuous supervision and consulting school crisis team or mental health professionals immediately

Resources

Reynolds, W.M. (1990). Depression in children and adolescents: Nature, diagnosis, assessment, and treatment. *School Psychology Review 19*, 158-173.

Stark, K. (1990). *The treatment of depression during childhood: A school-based program.* New York: Guilford Press.

Stark, K. et al. (1997). Depressive disorders during childhood. In G. Bear, K. Minke, & A. Thomas (Eds.), *Children's needs II: Development, problems and alternatives* (pp. 349-359). Bethesda, MD: National Association of School Psychologists.

NATIONAL
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Masturbation

A Handout for Parents

**by Ellie L. Young, Springfield (MO) Public Schools
and Richard Staples, Peabody, MA**

Background and Normal Development

Masturbation refers to deliberate touching or stroking of the sex organs. When observed in children, teachers and parents may have questions such as, "Is this normal?" and "How do I react?" This behavior may quickly create anxiety among parents and professionals.

Masturbation is part of normal sexual behavior throughout the life span — it is a natural act. Infants discover their genitals at a very early age, and masturbation reaches a peak around age four years, then diminishing somewhat until puberty. Research shows that 40-85% of children will engage in some sexual behaviors before they are 13 years old. In normal development, children have many interests, questions and playmates; sexual exploration is just one area in which children express curiosity. Natural and healthy sexual behavior during childhood is an information-gathering activity. A child who is masturbating may be trying to figure out how his or her body works. Girls learn how their bodies react and may learn how to achieve orgasm by masturbation; in general, boys learn how to delay orgasm through masturbation.

"Solo masturbation" is different from "interpersonal" or "mutual" masturbation and they serve different purposes. Solo masturbation provides sexual release and fantasy. Interpersonal masturbation is a safe and often non-threatening way to explore sex with another person. Younger children participating in playing doctor, or "show me yours, and I'll show you mine" games are attempting to understand gender roles and are usually close in age and developmental levels. They are usually voluntarily engaged in the play and share other play activities as well. Among Middle School children, mutual masturbation is usually one of the first sexual experiences with someone of the same or opposite sex.

It is not unusual for boys and/or girls to masturbate together. This does not mean that an individual is homosexual. Many boys and girls engage in some sort of same sex "play" and this does not determine or reflect adult sexual orientation.

For most children, their initial sexual explorations are not labeled as sexual either by the children or by the adults who observe them. Children do recognize the pleasure they feel and are aware of how adults react to them. When a young child is observed engaging in sexual play and told to stop, he/she is usually embarrassed, but does not express anger, anxiety, shame or fear. Generally, overt sexual play decreases with appropriate redirection.

What Can Parents Do?

Responding to a child who is masturbating requires some insight and reflection about the values of the family. Being aware of sexual values helps us intervene constructively. What were we taught about masturbation? Do we consider it an evil, dirty act? Is it a normal part of childhood development? What messages do we want the child to receive about sexual pleasure? How can we best communicate that message to the child?

A basic message might include, "I understand that you are curious about your body, and what you are doing feels good; we only touch ourselves in private." We may continue to explore the topic, depending on the age of the child, and if he or she has questions about how the body works. The child also needs to understand that being curious about his body is normal, and asking questions is appropriate. It is essential that adults discuss masturbation in a nonjudgmental manner in order to encourage questions and open communication. Communication is enhanced by giving the child the vocabulary to describe their thoughts, feelings and behaviors. While parents want to discourage masturbation in public places, it is important to address the behavior in a way that normalizes it so that the child does not feel "weird" or "bad." Helping the child differentiate "private" from "public" behavior, rather than "good" vs "bad" behavior, is key to helping children develop health sexual behavior and attitudes.

Parents and teachers need to be aware that a medical problem may exist, such as a yeast or urinary tract infection or, among uncircumcised boys, an infection underneath the foreskin of the penis. If the child's masturbation is a response to new or ongoing stressors, removing the stressor is an important step. If the stressor, such as a divorce or a family move, cannot be removed, then working with the child and family to increase understanding and coping skills is appropriate. If the child's sexual behavior is one of several behaviors that causes concern, a more thorough evaluation by a qualified and experienced mental health professional may be warranted. Your school psychologist can be helpful in identifying appropriate resources.

Resources

Johnson, T.C. (1996). *Understanding children's sexual behaviors: What's natural and healthy.* 1101 Fremont Ave. Suite 101, South Pasadena, CA: Copyrighted pamphlet by author.

Kelley, K., & Byrne, D. (1992). *Exploring human sexuality.* Englewood Cliffs, NJ: Prentice-Hall.

Madaras, L., & Madaras, A. (1995). *My body, my self for boys* and *My body, my self for girls.* New York: Newmarket Press. (Workbooks for early adolescents.)

Madaras, L. & Saavedra, D. (1988). *What's happening to my body? book for boys.* New York: Newmarket Press.

Madaras, L. & Madaras, A. (1988). *What's happening to my body? book for girls.* New York: Newmarket Press.

Martin, M., & Waltman-Greenwood, C. (Eds.). (1995). *Solving your child's school-related problems.* New York: Harper Perenniel.

Mayle, P. (1977). *Where did I come from?* New York: Carol Publishing Group.

Internet Resource

The "Masturbation Home Page" is written simply and can offer factual information. The easiest way to reach it is to use a search engine and type "masturbation" in the search window.

NATIONAL
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Obsessive-Compulsive Disorder in Children

Information for Parents

**by Robert S. Falk, Ph.D.
Richmond, Virginia**

Background

Obsessive-Compulsive Disorder (OCD) is defined by the American Psychiatric Association as recurrent obsessions or compulsions that are severe enough to be time consuming or cause marked distress or significant impairment. OCD is a fairly common childhood disorder, and symptoms may be observed as early as age three or four. Between 1 in 100 to 200 children suffer from OCD at any given time, or about one million children and adolescents in the United States. About 2.5% of the population has suffered from OCD at some point in their lives. Severity can vary from very mild, requiring no specific treatment, to very severe and impairing the child's daily functioning.

Obsessions are recurrent and persistent thoughts, images or impulses that the individual usually experiences as intrusive, unpleasant and senseless, although younger children may not recognize their obsessions as unreasonable. Negative feelings such as fear, disgust or a sense of incompleteness usually accompany the obsessions. Although recognized as a product of one's own mind, the child with OCD feels that she or he has little control over the obsessional thoughts. Common obsessions include being contaminated by dirt or disease; repeated doubts; fixation on illness, violent thoughts or images, or death; and fixating on lucky or unlucky numbers.

Compulsions are repetitive, purposeful behaviors that are performed in response to an obsession, in an attempt to neutralize or alleviate the negative feelings associated with an obsession, or to prevent a dreaded event. For example, individuals struggling with a contamination obsession may perform hand-washing excessively. The compulsions may conform to certain rules, such as counting or doing certain actions in a specific order. Compulsions can be either *observable*, such as the hand-washing example, or *covert*, such as counting or re-reading excessively.

Causes: OCD is a neurobiological illness that affects emotional states and interactions with others. Most of the available evidence points to a problem in brain pathways involving the "neurotransmitter" (a chemical messenger) serotonin. OCD *is not* the result of inappropriate parenting. Genetics play an important role in OCD and it is possible that other family members are also affected. Children with OCD are at higher risk for associated problems, including depression, other anxiety disorders, Oppositional Defiant Disorder (ODD), learning disabilities (LD), Attention Deficit Hyperactivity Disorder (ADHD) and Tourette Syndrome (motor and vocal tics). Therefore, a thorough diagnostic evaluation is crucial for effective treatment.

Impact: OCD can seriously affect schoolwork, home life and friendships. Although younger children may not understand that their thoughts or behavior is unusual, older children may be embarrassed by their symptoms and attempt to hide their rituals from friends and family. These efforts require considerable mental and physical energy. Compared to adults with OCD, children's symptoms may have greater impact on the family — they may insist on multiple washing of laundry, multiple checks of their homework or become upset when household items are "out of order" or when routines are not followed. The behaviors can lead to high levels of stress within the family and guilt on the part of parents who may feel they are the "cause" of the disorder. (Parenting does *not* cause OCD!)

Diagnosis and Treatment

A pediatrician, teacher, principal, school psychologist or counselor can help parents find appropriate resources for evaluating their child's behavior. A child psychiatrist will interview family members and perhaps school personnel in addition to interviewing and evaluating the child to diagnose OCD and rule out other disorders that may have some similar symptoms.

Treatment of Obsessive-Compulsive Disorder may include a variety of interventions, including individual psychotherapy, family therapy and medication. Traditional psychodynamic therapy has not proven to be helpful for OCD itself. As yet, there is no known cure for OCD. Occasionally children with mild OCD symptoms seem to "outgrow" the disorder, but this is unusual. More typically, the symptoms appear to "wax and wane" in intensity and persist into adulthood. The good news is that recent clinical advances have made effective treatments available. Most individuals with OCD are able to minimize the impact of the disorder and lead happy and productive lives.

Cognitive-Behavior Therapy and Behavior Therapy are helpful in the treatment of OCD. A variety of specific techniques may be used, including a particularly effective treatment termed *exposure and response prevention.* This treatment involves the child or adolescent being exposed to the "triggers" for their obsessions and compulsions, while refraining from carrying out the usual response. The OCD symptoms are lessened or eliminated through a process called "extinction." To be successful, the patient must be willing to tolerate high levels of anxiety that will occur during therapy.

Family Therapy involves education regarding the disorder and helping family members respond to the child or adolescent in the most therapeutic ways possible. Many children with OCD attempt to involve parents or others in their compulsions, and family therapy may help family members disengage from these rituals. A family therapist may also attempt to decrease the level of antagonism that may be felt as a result of the OCD symptoms. Research has consistently shown that punishment is of no value in the treatment of OCD.

Drug Treatment involves the use of medication to decrease the frequency and intensity of obsessions and compulsions. Drugs that alter the serotonin neurotransmitter system are effective in the treatment of OCD. Clomipramine (Anafranil), fluvoxamine (Luvox), fluoxetine (Prozac) and others have proven helpful. Drug treatment may be most helpful when combined with individual and family psychotherapy.

What Can I Do as a Parent?

If you suspect that your child has OCD, seek professional assessment. Identification of OCD is often difficult for mental health professionals and educators as well as parents because many OCD sufferers attempt to conceal their disorder. Sometimes termed "the secret disorder," OCD may not be directly observed in the home or classroom setting. Excessive seeking of reassurance, repeated insistence on doing things "just so," and rough, chapped hands from excessive hand-washing may be red flags. Remember that OCD is a *neuro-behavioral disorder* — a problem in the brain that affects your child's thoughts, feelings and behaviors. Being a biologically-based problem, OCD should not in any way be viewed as your child's fault or as a habit your child could stop by just trying harder. Some specific suggestions:

- ***Find a mental health professional experienced in the treatment of Obsessive-Compulsive Disorder.*** Your pediatrician or the OC Foundation may be helpful here. Work with your mental health professional in developing a workable treatment plan.
- ***Support your child's or adolescent's fight against OCD*** by disengaging from rituals and by "cheerleading" their efforts to conquer the obsessions and compulsions.

- ***Work with school personnel.*** If your child's OCD symptoms adversely impact school functioning, the teacher should be informed. Provide educational materials and arrange for consultation between your child's therapist and his or her teacher. If your child is on anti-OCD medication, the teacher and school nurse should be informed.

Remember that OCD is treatable. The child with OCD can be successful in school and in the community with the support of parents, mental health professionals and school personnel.

Resources

Dornbush, M. P., & Pruitt, S. K. (1995). *Teaching the tiger: A handbook for individuals involved in the education of students with Attention Deficit Disorders, Tourette Syndrome, or Obsessive-Compulsive Disorder.* Duarte, CA: Hope Press (1-800-321-4039).

Johnston, H. F. (1993). *Obsessive compulsive disorder in children and adolescents: A guide.* Child Psychopharmacology Information Center, University of Wisconsin, Madison, WI (available from the Dean Foundation, see below).

Organizations and Websites

Anxiety Disorder Association of America (ADAA), 6000 Executive Boulevard, Rockville, MD 20852. Voice: (301) 231-9350. Fax: (301) 231-7392. *<http://www.cyberpsych.org/adaa/index.html>*

National OCD Information Hotline: (800) 639-7462.

Obsessive Compulsive Information Center, Dean Foundation, 8000 Excelsior Drive, Suite 301, Madison, WI 53717-1914. Voice: (608) 836-8070. Fax (608) 836-8033.

The OC Foundation, Inc. P.O. Box 70, Milford, CT 06460-0070. Voice:(203) 878-5669. Fax: (203) 874-2826. Info Line: (203) 874-3843. *<http://pages.prodigy.com/alwillen/ocf.html>*

OCD Resource Center website: *<http://www.ocdresource.com>*

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Obsessive-Compulsive Disorder in Children

Information for Educators

Robert S. Falk, Ph.D.
Richmond, Virginia

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Impact: OCD can seriously affect schoolwork, home life and friendships. Although younger children may not understand that their thoughts or behavior is unusual, older children may be embarrassed by their symptoms and attempt to hide their rituals from friends and family. These efforts require considerable mental and physical energy. Children with severe OCD may exhibit their rituals at school. They may repeatedly go over assignments, erasing and redoing assignments, interfering with their concentration and participation.

Treatment

Treatment of Obsessive-Compulsive Disorder may include a variety of interventions, including individual psychotherapy, family therapy, and medication. Traditional psychodynamic therapy has not proven to be helpful for OCD itself. As yet, there is no known cure for OCD. Occasionally children with mild OCD symptoms seem to "outgrow" the disorder, but this is unusual. More typically, the symptoms appear to "wax and wane" in intensity and persist into adulthood. The good news is that recent clinical advances have made effective treatments available. Most individuals with OCD are able to minimize the impact of the disorder and lead happy and productive lives.

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The Role of School Personnel in Identification and Treatment

School personnel, including classroom teachers, school psychologists and administrators, can work as a team in the process of identifying, referring and educating children and adolescents with Obsessive-Compulsive Disorder.

Identification of OCD is often difficult for mental health professionals and educators. Sometimes termed "the secret disorder," OCD may not be directly manifested in the classroom setting. Possible cues for the presence of OCD include exceedingly perfectionistic behavior; over-erasure; rough, chapped hands from excessive hand-washing; difficulty completing work despite apparently adequate academic skills; or the child who will not give up his or her paper until he/she checks it "one more time."

Consultation with a school mental health professional familiar with OCD is the best next step for the concerned classroom teacher. If information collected by school personnel and parents strongly suggests OCD or other disorder, referral to appropriate resources in the community for evaluating the child's behavior is essential. A child psychiatrist will interview family members and perhaps school personnel in addition to interviewing and evaluating the child to diagnose OCD and rule out other disorders that may have some similar symptoms

Communication between the student services team, parents and the treating professionals is important in ensuring the best level of service possible. Keep in mind that, as with other chronic illnesses, some cases of OCD are mild enough to not warrant any specific school intervention. Others will require considerable adaptation, modification and perhaps special services from school personnel. Specific observations and behavioral data collected by school personnel should be shared with the child's parents. This will be more meaningful and persuasive than subjective impressions. It may be helpful to have more than one member of the school staff present for the initial conference. For example, the teacher and the school psychologist or other individuals involved with the student may be able to provide a variety of perspectives.

School-based behavioral interventions may be necessary if OCD significantly interferes with classroom functioning. Common problems requiring behavioral interventions include frequent requests to use the bathroom and compulsive reassurance-seeking. A collaboratively designed program involving the student, parents, school personnel and the community -based mental health provider may be quite helpful in these cases.

Daily management of OCD in the school setting requires an understanding and sensitivity to the disorder. Punitive consequences for behavior over which the student has little or no control (being tardy, absence from school for therapy appointments, missing "deadlines" because of compulsive behavior) may actually exacerbate the OCD. On the other hand, clear expectations and dependable structure often help children with OCD. Set clear limits, a regular classroom routine and establish reasonable consequences ahead of time.

Impact of medication and treatment: Be aware of changes in the child's behavior that may reflect medication or treatment effects. Negative side effects of medication may include drowsiness, dry mouth, irritability, fatigue, abdominal discomfort, diarrhea and/or constipation. Positive effects may include the reduction or elimination of ritualistic behaviors and obsessions, less difficulty attending to and completing work, and appearing happier. Share this information with parents, physicians, therapists and appropriate school personnel.

Resources

Dornbush, M. P., & Pruitt, S. K. (1995). *Teaching the tiger: A handbook for individuals involved in the education of students with Attention Deficit Disorders, Tourette Syndrome, or Obsessive-Compulsive Disorder.* Duarte, CA: Hope Press. (1-800-321-4039)

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Peer Relationships in Childhood

A Guide for Educators

by Carlen Henington, Ph.D.
Mississippi State University

Background

The importance of positive social interactions to social development has been well documented in the child development literature. Friendship is distinct from peer acceptance. Peer acceptance is having peers who like, or are willing, to play with a child. Friendship is mutual selection as a preferred playmate. Having reciprocal friends may protect against negative outcomes associated with low peer acceptance and loneliness. Also, friends offer an additional source beyond the family for companionship, emotional support and personal guidance. Specifically, friendship offers consensual validation of self-worth and competency; support of self-disclosure and expression of emotions; growth and sensitivity with regard to interpersonal interactions; and develops the foundation for later intimate relationships.

Children who experience friendship difficulties are more likely to experience later social maladjustment, including dropping out of school, employment difficulties, high levels of aggression and mental health problems. Additionally, being with friends during recess has been shown to enhance academic performance and increase concentration on academic tasks following recess in some children. Thus, it is little wonder that educators and mental health professionals have developed many intervention programs focusing on peer relationship- and friendship-building.

Elements of Friendship

1. Mutual affection and regard as demonstrated by an exchange of caring and a sense of responsibility for the other.
2. Investment of time and attention through shared interests and activities.
3. Commitment to the friendship and expectation that it will last across time.
4. Reciprocal loyalty to the other's interests.
5. Self-disclosure that fosters mutual understanding.
6. Equality of power in the relationship.

When considering these important elements of friendship, it is important to be aware of and have developmental expectations for the children. For example, expecting the friendship to last across time does not fit young children, as it is appropriate for them to have frequent changes in playmates during a play session.

Development

The following guidelines may be helpful in tracking developmental changes in and designing intervention to facilitate children's friendships:

Preschooler/kindergarten years: Young children form friendships based on availability, playmates are considered friends. Children chose playmates who are in physical proximity and who are engaged in a desirable activity. Play episodes are relatively brief with frequent changes in play partners. Common target skills include: building initiative and persistence in seeking play partners.

Early elementary school years: Friendship becomes more of an agreement or contract between playmates, complete with responsibilities and expectations for an exchange of favors and expected duties (birthday parties, sharing treats, unity — as opposed to loyalty). Play episodes are longer, but friendships may not be enduring. Common target skills include: making expectations explicit, keeping one's promise and building negotiation and appeasement skills.

Later elementary school years: Expectations become more sophisticated during this age. These include expectations for loyalty, mutual understanding and support. Children of this age spend increasing amounts of time (usually in games and sports) with friends (nearly twice as much) and the influence that peers exert over one another increases proportionally. Common target skills include: recognition of interpersonal obligations, generalization of negotiation skills to middle-childhood interests, conflict resolution skills and recognition of increasingly subtle social cues offered by peers to guide behavior.

Adolescence: Friendships no longer center around contracts; rather they increasingly resemble the friendships of adults. Friendship is based on mutuality, intimacy, shared support and loyalty. Common target skills include: building trust and empathy skills to support another's vulnerability that accompanies the sharing of intimate thoughts and personal experiences.

In addition to these specific friendship skills, intervention may be directed toward:

- Social awareness — recognizing cues regarding another's feelings, desires and understanding the intention of another's behavior;
- Social problem solving — increasing the number of choices of behavior in situations, the likelihood they will be enacted and generalizing skills from one situation to another.

Intervention

Who might benefit? Children who are experiencing friendship difficulty may be actively rejected or neglected by others. Children who are rejected by their peers and who do not have friends are more likely to be physically (e.g., hits, kicks, pushes) or relationally (e.g., tells rumors or lies, excludes others, manipulates friendships) aggressive than their peers. They may be unsuccessful at conflict resolution and negotiations over disagreements with others. They may be unable to compromise. These children often are unable, despite effort, to find playmates on the playground.

On the other hand, neglected children may have difficulty initiating social interactions. They may find it difficult to engage in play even when invited by other children. They often avoid aggression, and are often sensitive to teasing and roughness of other children.

Strategies: It is important to note that few interventions directed toward children who are experiencing peer and friendship difficulties are effective in the absence of social interaction in the natural environment. Children need to practice their skills on the playground in social situations with other children. Children naturally correct one another's social errors while in the process of playing and interacting. If a child does not have the opportunity to play with other children and to make social mistakes, little progress can be made toward developing spontaneous generalization of social skills outside intervention groups. Therefore, with the exception of safety issues, it may be more helpful to encouraged and assist children to resolve their own arguments and conflicts through problem solving, negotiation and compromise.

Resources

Social problem solving: Interventions in the schools (M. J. Elias & S. E. Tobias, Guilford Press, 1996.) *This book outlines steps toward developing and implementing interventions for social problem solving by the school practitioner in the educational setting. It includes suggestions at the classroom through the administrative levels. It includes a resource list for social skills programs for educators and parents.*

Children without friends: Implications for practice and policy (B. Doll, *School Psychology Review, vol. 25*, pp. 165-183, 1996).
This review article provides a current perspective on thoughts regarding friendship throughout childhood and outlines suggestions for school policy to facilitate children's friendships.

Children's social behavior: Development, assessment and modification (P. Strain, M. Guralnick, H. M. Walker, Eds., Academic Press, 1989).
This book examines the development of children's social relationship, provides methods for assessment of peer difficulty, and offers suggestions for intervention.

Peer assisted learning (K. Topping & S. Ehly, Eds., Erlbaum, in press).
This book is directed toward assisting educators to facilitate peer assisted learning which will indirectly increase peer social interaction.

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School Phobia/ School Avoidance/ School Refusal

A Handout for Parents

by Leslie Z. Paige, Ed.S., NCSP
Hays West Central (KS)
Special Education Cooperative

Background

School phobia/school avoidance/school refusal are terms used to describe children who have a pattern of avoiding or refusing to attend school. Different from truancy, these behaviors occur in approximately 2% of school aged children. Historically called "school phobia", many researchers now prefer to use the terms "school avoidance" or "school refusal". There is confusion regarding the terms because children who experience significant difficulty in attending school do so for different reasons and exhibit different behaviors. In general, children who refuse to attend or avoid school stay in close contact with their parents or caregivers, and are frequently (although not always) anxious and fearful. They may become very upset or become ill when forced to go to school. Truants may be distinguished from this group by their antisocial or delinquent behaviors, their lack of anxiety about missing school, and the fact that they are not in contact with parents or caregivers when they are avoiding school.

Development

Part of the confusion regarding the term "school phobia" is that the behaviors are not usually considered to be a true phobia. Although some children fear school-related activities (bus ride, reading aloud in class, changing for physical education), some are anxious about home issues or about being separated from a caregiver. Children become anxious for many reasons. "Separation anxiety" typically occurs at about the age of 18 to 24 months. Toddlers will cry, cling and have temper tantrums when they are about to be separated from their caregiver (for daycare or a babysitter, for example). This is normal at this age, but some older children continue to have difficulty separating from caregivers.

Sometimes school-aged children who were previously able to separate from their caregivers will suddenly become anxious and fearful. A recent crisis in the community or the family (such as a death, divorce, financial problems, move, etc.) may cause a child to become fearful or anxious. Some children fear that something terrible will happen at home while they are at school. Children who are struggling in school with academic or social problems may also develop school refusal. Many children have social concerns and may have been teased or bullied at school or on the way to school. Some neighborhoods or schools are unsafe or chaotic.

Children who have missed a lot of school due to illness or surgery may experience difficulty returning to the classroom routines as well as academic and social demands. Still other children prefer to stay home because they can watch tv, have parental attention, and play rather than work in school. Children and youth who are transitioning (from elementary to middle school, or middle school to high school) may feel very stressed. All of these factors may lead to the development of school refusal/ avoidance. Additionally, many children avoid or refuse school for a combination of reasons, further complicating treatment.

If untreated, chronic school refusal or avoidance may result in more than family distress. Academic deterioration, poor peer relationships, school or legal conflicts, work or college avoidance, panic attacks, agoraphobia and adult psychological or psychiatric disorders may result.

What Can Parents Do?

Prevention

Toddlers and preschoolers can benefit from structured experiences with other adults. Parents can help young children to separate from caregivers in several ways. Reliable and safe babysitting or daycare are excellent examples. Many communities have opportunities for preschoolers such as story hour at the library, preschool religious training such as bible school, recreational activities, preschool etc. When the child fusses at separation from the parent, the best strategy is to inform the child calmly that the parent will return and that the child is to stay. Then leave quickly. Children typically have more difficulty separating if their parents hover, linger, become upset, wait for the child to calm down or attempt to reason with the child . A firm, caring and quick separation is usually better for both parent and child. Preschool caregivers will typically report that the child's distress quickly disappears. However, children whose parents prolong the separation or who have had unsuccessful preschool separation experiences may need more time or support to calm down. This may be because they have learned that their distress results in parental rescue from separation! Successful preschool experiences ease the transition to preschool or kindergarten.

When Children Refuse or Avoid School

If complaints of illness are the excuse for not attending school, have the child checked by the family medical provider. If there is no medical reason to be absent , the child should be at school. The parent should attempt to discover if there is a specific problem causing the refusal. Sometimes the child feels relief just by expressing concerns about friends or school expectations. If the child is able to pinpoint a specific concern (such as worry about tests, teasing, etc.), then the parent should immediately talk to the child's teacher about developing an appropriate plan to solve the problem. Some common sense strategies to try include having another family member bring the child to school, or if the child does stay home then rewards such as snacking, tv, toys, or parental attention should be eliminated. A school schedule may be duplicated at home.

However, if the child is extremely upset, if the child needs to be forced to attend school, if there is significant family stress, or if the refusal to attend school is becoming habitual, the family should not hesitate in asking for assistance from the school psychologist, school counselor, or other mental health professionals. Parents and the school need to work together to identify what is causing or maintaining this behavior and to develop a comprehensive plan of intervention. A key to success is rapid intervention; the longer the behavior occurs, the harder it is to treat.

Treatment depends upon the causes, which can be difficult to determine. Many children may have started to avoid school for one reason (e.g., fear of being disciplined by a teacher, feeling socially inadequate) but are now staying home for another reason (e.g., access to video games, lack of academic pressure, etc.). Several treatment plans my need to be tried. Helping the child to relax, develop better coping skills, improve social skills, using a contract and helping the parents with parenting or family issues are all examples of possible treatments.

Resources

Martin, M. & Waltham-Greenwood, C. (1995). *Solve your child's school related problems.* New York: Harper Perenniel (School phobia, pp. 208-213).

Paige, L.Z. (1993). *The identification and treatment of school phobia.* Silver Spring, MD: National Association of School Psychologists.

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School Phobia/ School Avoidance/ School Refusal

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If untreated, chronic school refusal or avoidance may result in more than family distress. Academic deterioration, poor peer relationships, school or legal conflicts, work or college avoidance, panic attacks, agoraphobia and adult psychological or psychiatric disorders may result.

What Can Schools Do?

Monitor Students Carefully

A child who has experienced school refusal or avoidance in the past needs to be carefully monitored, particularly following vacations, the beginning of the school year, and following transitions to new schools.

Train Staff in Warning Signs

Staff inservice, particularly in the early elementary grades and in the transition years (i.e., first year in the middle school) can alert staff to warning signs. Teachers should be alert to students with the following characteristics, and should monitor closely:

- *Attendance patterns of frequent or chronic absenteeism*
- *Parents expressing concerns associated with their child's school attendance*
- *Absences without illness or other medical cause*
- *Resistance to attending school*
- *Developmentally inappropriate separation difficulties*
- *High levels of anxiety*
- *Behaviorally inhibited*
- *Recent family or school stressors which may precipitate school refusal*

Develop Intervention Plans

Teachers should not hesitate in asking for help from the school psychologist, social worker or counselor to develop a plan to help with chronic absenteeism. Communication and cooperation between the family, school staff and any other community service providers (physician, mental health) is critical for consistent and comprehensive treatment Teachers may be able to help by:

- *Providing classrooms that are caring, supportive, well-ordered and nonthreatening*
- *Greeting the child at the door and supporting the parent's rapid separation from the child*
- *Using sticker charts and small reinforcements with younger children*
- *Involving older children in designing intervention*
- *Communicating with family and community agency staff*

Resources

Kearney, C.A., Eisen, A.R., & Silverman, W.K. (1995). The legend and myth of school phobia, *School Psychology Quarterly, 10* (1), 65-85

King, N.J., Ollendick, T.H., & Tong, B.J. (1995). *School refusal: Assessment and treatment.* Boston: Allyn and Bacon.

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Selective Mutism

A Handout for Parents and Teachers

**by Thomas J. Kehle Ph.D.
and Melissa A. Bray
University of Connecticut**

Background

Children with selective mutism fail to speak in specific situations or settings, such as the school, although they freely speak in other settings. The condition is not the result of embarrassment over a communication disorder or the result of not understanding the spoken language. Further, the severity of the child's selective mutism negatively impacts their academic and social functioning. Additionally, excessive shyness, social isolation and withdrawal, negativism, tantrumming, anxiety and oppositional behaviors may also be present in children with selective mutism.

The onset is typically associated with the child beginning school. It is a rare disorder, found in no more than 1 per 1,000 children. It is also slightly more prevalent in females; however, other demographic variables such as the child's intellectual competencies, ethnicity and social economic status are not related to the incidence rate.

Development

Although there are several arguments regarding the cause of selective mutism, the majority of these can be described by either the psychoanalytic or the learning theory perspectives. According to psychoanalytic theory, selective mutism has multiple causes. These include trauma suffered during a critical period of the child's language development, a predisposition toward using mutism to reduce fear, an insecure environment and a family characterized by conflict.

Explanations of the cause of selective mutism based on learning theory argue that it is a learned response that is reinforced and maintained by the child's social environment. The reason that it is highly resistant to intervention may be because children with selective mutism are negatively reinforced for not speaking. Teacher requests for verbal responses are often withdrawn if the request, as it often does, distresses the child. Consequently, the child's selective mutism is negatively reinforced. In addition, classmates may reinforce the child for not speaking by interpreting the child's needs to the teacher.

What Can I Do as a Teacher?

Generally, successful treatment of selective mutism has been based on behavior techniques known as reinforcement, modeling, stimulus fading and shaping. In addition, self-modeling, in combination with several behavioral therapy techniques, has been successful. Based on the assumption that selective mutism is a result of a social phobia (unrealistic fear),a medication (fluoxetine, known as Prozac) is sometimes prescribed that has also been shown to be beneficial in treating social phobias. Recently, fluoxetine combined with self-modeling and specific behavior therapies has been shown to be an effective treatment strategy. Although teachers should be aware of treatment strategies that involve pharmacological interventions, their role would primarily involve monitoring.

Within the classroom, the following techniques and strategies have been shown to be effective:

- ***Reinforce the child for any verbal behavior,*** while simultaneously ignoring the child's non-verbal responses.
- ***Use fading:*** Involve the child in a situation where there is a high probability for normal speech and then gradually fade into that setting individuals with whom the child was previously mute. There are several ways the teacher can fade other individuals into such settings that have a high probability of speech for the selectively mute child. For example, if the child displays normal conversation during a board game with his/her siblings, invite them to play the game in the classroom after school. Assuming that the child will be actively and verbally engaged in the game, the teacher can gradually introduce classmates, with whom the child was previous mute, into the game. Another example is to take the child with selective mutism to a restaurant (assuming that the child has a history of normal speech in this setting) and after the child orders and sits down at a table with other individuals he or she normally converses with, gradually fade into that setting a classmate or two whom which the child was previously mute.
- ***The teacher can reinforce successive small approximations*** toward normal conversational speech. For example, the teacher can first have the child first write responses to teacher questions, then reinforce the child's written response if it is accompanied by the child making some noise. Following this, the teacher can reinforce the noise, subsequently shape the noise to humming, repeating letters, reading small phrases, and to finally, speech.
- ***"Mystery Motivators":*** A rather simple strategy that teachers may find beneficial are mystery motivators. A manilla envelope containing a facsimile of a valued gift can be placed on the classroom's bulletin board. On the envelope is written the child's name and a big question mark. The children are informed that in the envelope is a "mystery" motivator, a gift for the child with selective mutism. Further, the child would receive the gift when he/she asked for it in a normal tone of voice.

What Can I Do as a Parent?

Parents can be valuable allies to classroom-based interventions designed for children who are selectively mute. The most successful strategies tend to be conducted in those settings that the child selects not to converse in, such as in the school. Consequently, the following should be considered:

- ***Volunteer in the classroom:*** Often times, because the child conversely freely in the home, the parents may not fully comprehend the degree and seriousness of the problem in the school setting. Volunteering as a teacher's aid in the child's classroom will allow the parent to become familiar with the extent and pervasiveness of their child's mutism.
- ***Collaborate with school personnel:*** The parents, when collaborating with the teacher and school psychologist, can substantially improve the probability of success with the above mentioned school-based techniques.
- ***Only reinforce verbal communication:*** Parents should not reinforce any of their child's attempts to non-verbally communicate by interpreting the child's needs to other individuals, relatives, store and restaurant employees, etc. For example, if the child asks their mother to order a McDonald's happy meal for them, the mother should not comply. However, if the child does verbally communicate with other individuals, their verbal behavior should be reinforced.
- ***Consult physician regarding medication:*** Parents may also wish to consider consulting with their pediatrician in regards to the use of fluoxetine. Fluoxetine has been employed successfully to treat selective mutism. Perhaps the best approach is to use the medication together with behavior strategies in order to prompt normal verbal behavior. The fluoxetine can be withdrawn after the child's verbal behavior can be clearly maintained by the reinforcing aspects of the natural environment.

Resources

Kaplan-Tancer, N. (1992). Elective mutism: A review of the literature. In B. B. Lahey & A. E. Kazdin (Eds.), *Advances in Clinical Child Psychology (Vol 14)* (pp. 265-288). New York: Plenum Press.

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Self-Esteem

A Handout for Parents

by Tracy Simonson, Ph.D.
Miami University (OH)

Background

Our knowledge about ourselves often includes ideas such as "artistic", "athletic", "creative", and/or "tall." These ideas make up our self-concept — "Who I am." An important component of self-concept is self-esteem, which represents how we feel about or value ourselves.

Self-esteem is important because poor self esteem has been associated with depression, suicide, low academic achievement, susceptibility to peer pressure and delinquency. Although causal links between self-esteem and these problems are difficult to establish, many educators believe that self-esteem appears to be a necessary (although not sufficient) condition for successful life adjustment.

The Development of Self-Esteem

Beginning at age 8, children not only have a global sense of self-esteem, they also evaluate their competencies in five areas: 1)scholastic competence; 2)athletic competence; 3) social acceptance; 4) physical appearance; and 5) behavioral conduct.

In some instances, children are able to discount the importance of areas in which they feel less competent. For example, a child can indicate a low evaluation of his/her competence in athletic ability but it will not negatively affect self-esteem because the child has discounted his/her performance in this area ("sports are not very important to me"). Therefore, low self-esteem is a result of a *discrepancy* between the importance of an area and one's perception of competence in that area. A child who sees scholastic achievement as important will have low self-esteem if he/she is doing poorly in reading or math.

Research has also documented the importance of positive regard from significant others, primarily parents, peers and teachers, as a critical determinant of self-esteem. Positive regard can be unconditional; a child feels loved and accepted regardless of his/her ability or behaviors. However, positive regard from others is conditional when a child feels loved and accepted only when he/she meets the high standards of others. Conditional positive regard is devastating to self-esteem.

Characteristics of Children with Low Self-Esteem

The following behaviors may be indicative of low self-esteem:

- A reluctance to learn new things or an avoidance of challenge. Children with low self-esteem may ask parents for help or refuse to do things by themselves.
- Frequent negative self-statements ("I can't;" "I'm not good at anything").
- Excessive criticism of others and/or possibly downplaying the achievements of siblings or peers.
- Reactivity and dependence on external cues. Children with low self-esteem may be highly sensitive to verbal and non-verbal cues as they search for feedback on their performance. They may react strongly to some cues, such as a frown or sigh from parents. This is despite being assured that the negative cue was unrelated to their performance.
- Overreaction to mild anxiety-provoking stimuli such as time constraints, healthy competition, or constructive criticism.
- Easily influenced by peers.
- Very reactive to the ups and downs of daily life. Failure can be devastating, even on minor projects.

Suggestions for Parents

1. Take a good look at your parenting style. Parents who are warm, accepting, concerned and affectionate often have children with high self-esteem.
2. Create a harmonious home through clear and fair rules, consistent and fair discipline. Allow opportunities to discuss disagreements within the family.
3. Allow your child some choice and control in daily activities within prescribed limits. Picking out clothing for school, choosing one meal a week, or selecting the book to be read at bedtime may communicate to a child that his/her opinions are trusted and valued.
4. Be familiar with your child's strengths and weaknesses as well as his/her present level of ability. Make reasonable demands for performance based on improvement by your child rather than comparisons with peers, siblings or developmental milestones. Discourage your child from making these same comparisons.
5. Establish "family time" on at least a weekly basis. Decide on a time where the television is turned off, the phone goes unanswered and the family spends quality time with each other. Allow each child to choose the activity on a regular basis.
6. Let your children know that you have confidence that they can do things on their own. Refer to past struggles and point out how they were able to overcome them ("Remember when you had trouble making your bed — you stuck with it and now it is easy for you.").
7. Assign your children manageable age-appropriate household chores. Expect them to complete them everyday with minimal reminders. Use specific task feedback and reward close approximations.
8. Be sure to encourage and support your children. Do not make love and support conditional on a child's efforts or behaviors. Make sure that your children know that you may be displeased or disappointed in a behavior but that they can always depend on your love.
9. Model good social problem solving skills. Stress using words to express feelings and discussion as a way to solve family problems. Help your children identify their feelings through reflective listening ("you look disappointed about not winning the game.").
10. Encourage children to develop a wide range of skills and hobbies that they can feel successful at. Remember that self-esteem is developed through evaluations of ability in several areas, not just academic achievement.

Resources for Parents

Clemes, H. & Bean, R. (1990). *How to raise teenagers' self-esteem.* New York: Price, Stern, Sloan.

Fuller, C. (1994). *365 ways to build your child's self-esteem.* Colorado Springs, CO: Piñon Press.

Loomans, D. & Loomans, J. (1994). *Full esteem ahead: 100 ways to build self-esteem in children and adults.* Tiburon, CA: J. Kramer, Inc.

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Self-esteem is important because poor self-esteem has been associated with depression, suicidal ideation, low academic achievement, susceptibility to peer pressure and delinquency. Although causal links between self-esteem and these problems are difficult to establish, many educators believe that self-esteem appears to be a necessary (although not singularly sufficient) condition for successful life adjustment.

Development of Self-Esteem

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In some instances, children are able to discount the importance of areas in which they do not regard themselves as competent. For example, a child can indicate a low evaluation of his/her competence in athletic ability but it will not negatively affect self-esteem because the child has discounted his/her performance in this area ("sports are not very important to me"). Therefore, low self-esteem is a result of a *discrepancy* between the importance of an area and one's perception of competence in that area. A child who sees scholastic achievement as important will have low self-esteem if he/she is doing poorly in school.

Research has also documented the importance of positive regard from significant others, primarily parents, peers and teachers, as a critical determinant of self-esteem. Positive regard can be unconditional; a child feels loved and accepted regardless of his/her ability or behaviors. However, positive regard from others is conditional when a child feels loved and accepted only when he/she meets the high standards of others. Conditional positive regard is devastating to self-esteem.

Characteristics of Children with Low Self-esteem

The following classroom behaviors may be indicative of low self-esteem:

- A reluctance or inability to start new tasks independently
- Resisting more challenging work and/or setting low achievement goals
- Frequent negative self-statements ("I can't;" "I'm not good at anything")
- Excessive criticism of others and/or possibly downplaying the achievements of classmates
- Reactivity and dependence on external cues. For example, a child may not be able to begin work on a project until knowing how everyone else is going to do it. Children with low self-esteem may also overreact to anxiety-provoking stimuli such as time constraints.
- Easily influenced by peers
- Very reactive to the ups and downs of daily life. Failure can be devastating, even on minor projects.

Suggestions for Teachers

When approaching the issue of self-esteem within the classroom, it is important to remember:

1. Self-esteem is most amenable to both positive and negative change at times of transition. This is because of a revision of evaluations of competence, aspiration and social networks.
2. Children with intermediate levels of self-esteem are more amenable to change than those with very low levels.
3. Self-esteem is a fairly stable entity. Isolated programs that are time-constrained are not likely to be effective.

Strategies: The most progress will be found when classroom procedures and curriculum are systematically changed to enhance the esteem of all students.

1. Try to include classroom activities that focus on a child's importance and belongingness to the community of the classroom. For example, after a trip to a farm, a common activity would be for each student to comment on "What I Saw at the Farm". Instead, the entire class might be asked to draw a graph of how many of each animal were observed by all of the students as a group.
2. When possible, use portfolios to help students monitor their progress. Have each child develop selection criteria for taking projects home.
3. Restructure your classroom to avoid competition and comparisons between children; public display of class standing can be devastating and embarrassing for children on the lower end. Cooperative work groups are an excellent strategy to allow each child to make a contribution to a project and feel part of the classroom community.
4. Encourage inquisitiveness and exploration in your students. Respond positively to questions asked during lessons, and include a child's questions or concerns in further lessons where appropriate ("this is similar to the issue that Anna brought up yesterday"). If you treat each child's concerns and questions with respect, they are more likely to raise issues in further discussion and to take their own ideas seriously.
5. Ask for children's views and preferences on various classroom activities; make them feel like an important part of the classroom community. Although you should respectfully consider all preferences, the class should understand that you have the final decision.
6. Help students remember past struggles and how they were effective in overcoming it ("Remember when you had difficulty mastering addition of fractions? I'm sure that you will be able to understand finding a common denominator.").
7. Examine your curriculum to be sure that lessons are at each child's zone of proximal development; that is, slightly above their current skill level so that they can feel both challenged and successful.
8. Encourage rather than praise students. Make sure encouragement is specific, takes place in private to avoid comparisons, and focuses on improvement of the process rather than evaluation of the end project. For example, if a child finished a project independently, you might say, "You must be pleased with yourself for finishing the paper all by yourself."
9. Teach problem-solving skills as part of the curriculum. When assigning a long paper, spend some time with students regarding how to approach it and how to manage their time. Help students anticipate pitfalls and develop strategies for how to handle these situations.
10. Help students explain their failures not as resulting from lack of ability but from inadequate effort, task difficulty, unrealistic aspirations, improper planning, etc. Give them motivation to do something different and try it again.

Resources

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Sexuality and Adolescents

A Handout for Parents

by Richard B. Staples, CAGS
Peabody, MA

Introduction

Adolescence is a time of transition between childhood and adulthood. "Transition" reflects movement, development or evolution from one form, stage or style to another. It is important to view adolescence as a process of incremental changes. It is generally accepted that the beginning of adolescence is marked by the development of secondary sex characteristics, i.e., body hair for boys and girls as well as ejaculation for boys and menstruation for girls.

Boys and girls develop at different ages and different rates. Girls generally precede boys by approximately two years. Girls can begin to show signs of development as early as age nine, where boys usually begin to show signs of development at age eleven. It is common to see physical changes in both sexes by fifth grade. There are also emotional, social and "attitudinal" changes that occur simultaneously but may not be as visible. When recalling their first conscious sexual thoughts, most students report these occurred at about age nine years. While middle childhood might be termed the "latency period," when psycho-dynamic theorists claim sexuality is suppressed, this period is characterized by physiological and cognitive changes that children may not discuss unless an adult "sets the tone" for a non-judgmental and sensitive discussion.

Sexual development is a major part of adolescence. Sexuality flows from the onset of physical changes. It is an inevitable, universal occurrence. The typical changes in adolescence for girls and boys include body growth, the development of body hair, and increased output of oil/sweat producing glands. Specifically, for girls, the changes include menarche and breast development. Specifically, for boys, there is growth in the testicles, the scrotal sac and the penis; ejaculation also occurs around this time. Ejaculation may occur in the form a nocturnal emission or "wet dream" or the boy may ejaculate by masturbating.

Developmental Issues

As boys and girls progress through the changes of adolescence, they are acutely aware of their peer group. Adolescents are consistently evaluating themselves and comparing themselves to their classmates. There is intense pressure to conform to the group norms that are present in their culture and adolescents can be extremely impatient with peers who stray from what is considered "normal" development. The concept of *body image* becomes very important to both boys and girls. For purposes of clarity, body image is defined as how a person feels their body communicates their character or "What does my body say about who I am?" and the individual's degree of satisfaction with this communication. There is a tendency in our society for people's level of competence to be based on their appearance. Adolescent culture is no different and adolescents can be very judgmental. Impressions can become reality with adolescents because they are hypersensitive to social approval.

Body type becomes a focus of attention in adolescence. Girls begin to become weight-conscious and can be greatly influenced by the media as to what is "socially acceptable." Boys tend to become fascinated with muscle development, weight lifting, athletic prowess and physical power that can be translated into some sort of status in their peer group.

Early maturing adolescents: Early maturing girls tend to have difficulty within their peer group. They are often the focus of unwanted attention from boys and can become self-conscious of their body development. Early maturing boys are often quite popular because they are "ahead" of their male peers, are usually more socially sophisticated and gain popularity in sports.

Late maturing adolescents: Boys generally struggle when they are slower to reach puberty. They typically do not enjoy the recognition from their early maturing age-mates and are clearly at a disadvantage in most sports. Their small stature creates a situation where they are treated as if younger. Girls who are late in maturing can be at an advantage because they are maturing at the same time as their male peers, and this can lead to the development of common interests. Comparisons with their female peers, however, can cause feelings of rejection and lowered self-esteem if the delay of puberty is significant.

Self-esteem: There are some differences in how boys and girls acquire self-esteem. Boys tend to acquire self-esteem by being viewed as capable and proficient in some sort of activity. Girls tend to acquire self-esteem by being viewed as popular and well-liked by other people. Self-esteem is really how someone feels about the unique talents and strengths that make them who they are. Generally, boys value physical activities and judge themselves by their physical skills. Simultaneously, the girls are influenced by the images portrayed in the media about the female body and are judging themselves by this standard. The development of high or low self-esteem depends on the degree to which the boy or girl feels he or she measures up to these standards.

Developing sexual behavior: Just as the development of self-esteem is different for boys and girls, the development of sexual behavior is different as well. Generally, girls tend to focus on romantic fantasies and the expression of emotions as a way to become close to their male peers. Boys tend to focus on sexual activity and in some instances define the depth of a relationship by the extent of the sexual behavior in the relationship. Masturbation is common to both boys and girls. Most adolescents do not consider engaging in sexual behavior as "right or wrong." Rather, they make a decision based on the quality of the relationship of the partners. Sexually experienced male adolescents tend to have relatively high self-esteem, whereas sexually experienced females tend to have low self-esteem. However, for both sexes, early sexual activity can be associated with other problem behavior, such as drug use and delinquency.

Because adolescents are very impressionable, it is imperative that their access to pornographic materials be monitored. It is also important that parents remember that they are role models for their children and create an atmosphere where sexuality is viewed as healthy and nurturing.

Gay, Lesbian, Bisexual and Questioning Teens

Contrary to what some people would like to believe, adolescents do not become gay when they become freshman in college and move away from home. In their work with gay, lesbian, bisexual and questioning youth, many professionals have found that most adolescents become aware of their feelings in middle school. Some can reflect on feelings they had earlier but at that time they were unaware of what those feelings were all about. This is a subject that is almost never discussed within the family or classroom. It is a subject that parents need to "put on the table" so that your adolescent knows it is open for discussion. This is a time that your own feelings regarding sexuality need to be very clear. Your nonverbal communication will be more powerful than your verbal communication and your attitude can open or forever close the subject with your adolescent. Adolescents can suffer quietly because sexual orientation is tied to self-esteem. Being anything other than heterosexual is being "different" and, as stated previously, adolescents have a very difficult time being different.

Suggestions for Parents

As a parent, you must recognize that adolescents' sexuality embraces much more than the physical acts of sex and the development of their bodies. It also includes how their bodies respond sexually and how they feel about those responses. It includes what they think is right and wrong related to sexuality. Decision making and moral development are clearly intertwined at this juncture. Adolescents' role models are critical and it is important that the adolescents have someone to "talk things over with." There will be a lot of confusing questions because sexuality is generally a subject that produces a certain amount of anxiety when initially discussed. The following guidelines are adapted from Gale's *A Parent's Guide to Teenage Sexuality:*

- ***Be a knowledgeable resource.*** First, make sure that you are knowledgeable yourself. There are several good publications that are clear and easily read. You can find them at most book stores or public libraries. You do not have to be the "expert" and be able to answer all of the questions. It is far more important that you are empathic, understanding, supportive and non-judgmental. This will "keep the door open" and give your adolescent permission to come back for repeated discussions. To borrow from the work of Steven Covey in his book, *The Seven Habits of Highly Effective People*, "begin with the end in mind." Consider what message you want your adolescents to gain from the discussion.
- ***Eliminate distractions.*** Turn off the T.V., radio, turn on the answering machine and spend the time alone with your adolescent. Nothing should come between you and your adolescent.
- ***Clarify an unclear question.*** Summarize what you think your adolescent wants to know. It will help them to understand that you are really listening and give them the opportunity to correct any misunderstandings.
- ***Don't interrupt.*** This is important because if your adolescent is anxious, his or her questions may be disjointed or generated slowly. Give them time to formulate their thoughts and communicate those thoughts. Don't "jump the gun" and finish their question for them.
- ***Use "I" statements.*** This is one of the best ways to communicate in a non-accusatory fashion., i.e., "I feel _____ when you" or "I'm concerned about you because ... ".
- ***Arrange "time to talk."*** Honesty, sincerity and morality should guide your discussions with your adolescents. "The facts" are important but do not forget that your adolescents will have some feelings about those facts. Do not underestimate the moral issues either. Your adolescents are actively thinking about how old you should be when you "do it for the first time," "What do you do on a first date," "How do you know when your relationship is ready to go further." Sexual decision making is part of sexuality and is often eliminated in sex education classes because, by some standards, a public school health class is not the place to communicate morality and values. You as the parent are in the optimal position to do that. Your adolescents really do want to talk with you.
- ***Address "safe sex."*** Although you may strongly emphasize abstinence with your teenager for both moral and health reasons, you can't really control their behavior to the degree you might wish. If you have established an open, nonjudgmental communication system with your adolescent, you will be available to answer questions and provide guidance. Above all, emphasize the importance of safe and responsible behavior, to prevent pregnancy and to prevent sexually transmitted disease.

Resources

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Website

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Sexuality Education for Young Children

Guidelines for Parents and Preschool Staff

by Nicola Jordan, Ed. D., NCSP
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What is Sexuality?

Sexuality is a broad term that includes our bodies and how they work; our genders; our sexual orientation; and how we value love, life and relationships. Sexuality is central to everyone's development beginning before birth and lasting until death. It's also an area that causes many adults great discomfort. In our discomfort, we often ignore the topic, hoping that sometime in the future our children will learn what they need to know in a "sex ed" class at school or church or, if and when the proper words and inspiration strike us, possibly at home.

Why is Learning About Sexuality Important for Young Children?

No matter how much we resist raising the topic with them, young children are learning about sexuality, and often they're learning and developing attitudes about sexuality in ways that are unplanned and even hazardous. We're all aware of society's very mixed messages about sex: from the evocative and exploitative images in the media to the embarrassed silence of many adults who are perfectly willing to teach other subjects, but are *not* ready to broach the topic of sex. In the midst of this confusion, we are all horrified by reports of sexual abuse of children. Our youngest ones need protection more than ever.

It is worth noting that many school policies are now mandating sexual abuse prevention and AIDS awareness programs that target children of all ages. Too often these are being implemented in the absence of any overall sexuality education plan. Imagine the effect of introducing young children to sexuality by highlighting injury, illness and death. Those are scarcely the images of sexuality that provide a healthy and positive basis for learning. So, whether we like it or not, our young children are finding out about sexuality from many sources, and we must become informed and involved to ensure that they're learning what we want them to learn. The purpose of this summary is to review some of the issues that need to be addressed and some of the characteristics of appropriate sexuality education. These messages are for both parents, who are their young children's most important teachers, and staff of early childhood programs, who also form strong attachments to their charges and often are parents themselves. The cornerstone of successful sexuality education is the ongoing communication and cooperation among all care givers of young children.

What is Appropriate for Young Children?

There are two ways to speak to this question. First, let's look at what kind of behavior and needs are typical of preschoolers, and second, with that in mind, we can consider what kind of sexuality education is appropriate at these ages. Obviously the behaviors and learning of young children are very different from those of older school-age children.

From birth to age two: The development of the senses is the central task of infancy. Babies are learning from birth how they're touched, soothed, held, fed, changed and dressed. They're beginning to explore and learn about their body parts, including their genitals. They develop attitudes about their bodies depending on the responses they receive from their adult caretakers, and they begin to develop a male or female identity and to learn what behavior is expected for boys and girls.

Three and four years: Children at these ages continue to be increasingly curious about body parts, and self-pleasuring or masturbation remains common, as is a variety of sex play ("house" and "doctor") with friends and siblings. "Bathroom humor" and curse words are often noticeable, and threes and fours begin wondering about pregnancy, birth and where they came from.

Five to eight years: In this age group children are becoming clear about whether they are boys or girls and have a basic idea of what that means. Their understanding of where babies come from is changing through this period, with 5-year-olds often stating that the baby came from a specific place: the store or hospital. Gradually they may move on to believing that babies are somehow "manufactured" (the mommy ate something that grew inside her stomach). Such myths about birth and sex are typical, and we shouldn't be alarmed. However, caregivers need to help children move beyond myths to a more accurate understanding.

How Can Parents and Caregivers Help Young Children?

It's not necessary to possess a large body of knowledge or to prepare a lecture in order to help young children learn about sexuality in a positive way. There are many simple everyday actions that contribute significantly to healthy sexual development. Furman emphasized the slow, ongoing process of teaching children "ownership" of their bodies through careful supervision and responsive and responsible interactions with adults. A safe, clean environment with adults who listen and are available to help when needed provides a foundation for children's education. Responsible adults (parents *and* teachers) meet the child's basic need for trust and stability. They are also children's most important role models, and if they are open and honest, children will communicate with them. Thus, without realizing it, you may already be doing some of the most important things to promote healthy sexuality.

Be "shockproof" and use accurate terms: In addition to being good responsive listeners, parents can offer some specific help to their children. First of all, to be "shockproof." Even when stunned by a child's language or behavior, we must respond calmly. An outraged expression that says sexual curiosity is "bad" is a sure route to closed communication. When a 3-year-old shows an adult his erection or a 4-year-old draws a naked person with astonishing detail, he is showing curiosity, as well as trusting the adult. He is not being "bad" or "dirty." When talking about the body and responding to questions, it's important for us to use the correct vocabulary for parts and processes. Young children are just as capable of learning the words penis, vagina and breast as they are the "street" terms. Accurate vocabulary also helps raise the level of the conversation and provides a basis for preventing or eliminating children's use of obscenities or put-downs.

Respond to questions: While often dreaded by adults, children's questions about sex can also be viewed as "teachable moments." If we don't know an answer, it's acceptable to admit it and agree to find out (and then do it and get back to the child). At times it's difficult to know just how much information a child wants. Usually this can be determined by responding to the child's question with a question of our own: "How do *you* think babies are made?" And then go on from there with correct but simple information. A lengthy treatise isn't necessary, as children will usually tune out after they've heard what they want, which often is less than the parent fears. See the books listed under 'Resources' for some specific suggestions for helpful wording.

Respond to behaviors: In addition to being calm and shock-proof, adults need to set limits on the sexual behavior of preschoolers. If a child is masturbating in the grocery store or the preschool classroom, the caretaker could say, "That must feel good, but that is something to be done in private. Tell me what a private place is where that would be OK." If children are found without their clothes on, playing "doctor," the adult could calmly but firmly see that they put their clothes back on, while saying, "We keep clothes on. If you want to know more about what other people's bodies look like, we can look at this book together and talk about it."

Communicate about feelings, making decisions and solving problems: When parents and teachers encourage children to let others know what they're feeling, they are encouraging respect for each other and for privacy. They are also helping children learn to speak for themselves and to use alternatives to crying or hitting. If one child is touching, pushing, taking a toy, etc., the "victim" needs to be encouraged to communicate to the offender how s/he feels about the intrusion: "I don't want to be hugged," "I'm not ready to share this truck yet."

Likewise, when we encourage children to become involved in making decisions and solving problems at simple levels, we are indirectly teaching skills that are intrinsic to sexuality education. While many decisions and problems are too difficult for children, adults can help "set up" choices that are appropriate for children and start training them in how to become good decision-makers, e.g. choosing between two toys or activities. Children can also be enlisted for group problem solving to show that it can be fun to come up with solutions, e.g., how will everyone get a chance to play with this new toy, or how can we get cleaned up so we'll have some play time?

Allow for different backgrounds and values: Our own childhood experiences strongly affect how and when we approach sexuality with our children. Different cultures, religions and family values contribute to different degrees of comfort with the topic as well as to different approaches. Some parents have found that while they might become more comfortable with responding to their own children's questions, they don't know what to do when neighbors' children are visiting, for fear that other families might not share their beliefs or approve of their approaches. Similar difficulties are faced by preschool staff, and it's imperative that all of us recognize and respect families' various beliefs and attitudes.

What Can Parents Do?

- Arm yourselves with literature that addresses both parents and young children (see 'Resources') to become as informed as possible.
- Reflect on your own sexuality education and basic beliefs in order to pinpoint possible trouble spots and to establish what values and attitudes you want to maintain with their children.
- Discuss the topic with other parents and with preschool staff members.
- Examine preschool policies on both sexuality education and sex abuse prevention programs. If they seem limited or deficient, and if no one else is addressing the problem, consider helping to organize workshops or discussion groups to develop them. There are materials for such workshops available, and trained community leaders could be asked to implement them.

What Can Preschool Staff Do?

- Consider all of the suggestions for parents: self-education, reflection on attitudes and experiences, discussion with other staff members and parents, plus policy and workshop development.
- When children's comments, questions and activities are sexual in nature and when staff members present new material, e.g., dealing with a mother's pregnancy or a sibling's birth, keep the parents informed. It's always better to be "up front" with parents about any potential problem situations than to hope that no one finds out (they always seem to anyway).
- Allow parents to have their children "opt out" of any discussions or activities with which parents feel uncomfortable. Some families feel strongly that these issues should be addressed with their children only at home.

How Can Adults Help Each Other?

In today's world when dealing with such a difficult topic, we need all the help we can get. The more we can talk together about sexuality with accurate vocabulary, matter-of-fact attitudes and non-punitive and guilt-free approaches, the healthier, more responsible and respectful our children will be. In so doing, important steps are also taken for protecting children from sexual abuse, as they and their caretakers become increasingly able to talk about these issues, to communicate their rights and needs, and to make positive choices. Families and teachers working and learning together can provide a solid, respectful and healthy foundation for learning about sexuality.

Resources

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For young children:

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Stress in Children

A Handout for Parents

by David Streight, Portland, OR
and Ellis P. Copeland, University of Northern Colorado

Overview

Stress is a feeling of discomfort that is experienced somewhat differently by children and adults and from one individual to another. Our world is full of situations and events that cause stress — unemployment, marital tension, death of a parent or sibling, serious illness or injury, unexpected bills, etc. Particularly for children, stressful events might include parents' divorce, abuse or neglect, poverty, school failure or illness. Even positive events can create a degree of stress — such as moving to a new home, a new job, a new baby in the family, etc. Although a certain amount of stress is good, life today presents most of us with more stress than we want or need. The age of the computer, of instant information, of instant evaluation of our actions, rather than making life easier — as we always thought it would — has added to the expectations that others have of us or that we have of ourselves. With a little more time, we feel that we can always do "just a little bit more."

It is important to distinguish daily life "hassles" from significant stress. Parents and children experience such common hassles as waiting in line (at the bank, in the school lunch line), changes in daily routine, rescheduling appointments, conflicts with family members or friends, etc. Generally, children (as well as adults) learn strategies to effectively cope with these small hassles. Significant stressors, such as a death, loss of income or serious illness, are more likely to catch children or adults unprepared to cope. These events result in serious consequences for the individual's physical and emotional well-being. However, while life's "hassles" generally have less negative consequences, the cumulative effect of many such "hassles" can be as detrimental as any single traumatic event. The perception of stress is also related to experience and development — what is stressful for one person may not even amount to a small hassle for another. The ability to evaluate stress level and to develop coping skills increases with age and cognitive development.

Our environment is stressful. But much of our stress is caused by our mental attitude in conjunction with the environment. Can you remember a time when something happened that nearly sent you "through the ceiling" in anger, even though on another day the same event might have bothered you very little? This is an example of the effect of our thoughts on our mood. Having to get something done for a sympathetic loved one is much less stressful than having to get the same task done for a boss, a teacher or another individual who has power over us or whose expectations we feel we have to meet. Thus, it's not the situation that causes all the stress. Our beliefs about the situation are a big piece of the puzzle.

Although different individuals will find different events more or less stressful, stress in children is usually caused by:

- New, unfamiliar or unpredictable situations
- Unclear expectations
- Expectations of something unpleasant (e.g., pain)
- Fear of failure (socially or academically)
- Major developmental "hurdles" (moving from elementary to middle school, leaving home)

Symptoms of Stress

The effects of stress vary from one person to another and each person may develop unique symptoms or individual styles of handling stress. Some environments (e.g., homes, schools, etc.) are more stressful than others. Additionally, constitutional factors, including gender and temperament, play a significant role in how stress is perceived and handled. Stress is cumulative and progressive, and improved resources and coping skills are often necessary to reduce its ill effects.

There are generally three recognized stages of stress marked by phases of physical changes: alarm, resistance and exhaustion. In the first stage of stress, the body goes into "red alert" — with an increase in heart rate and breathing as the individual considers a course of action. This is followed by "resistance" where the body attempts to slow down and return to "normal." If the stressful event continues or if the individual is unable to adapt to the situation, exhaustion may follow.

Symptoms of stress in children: Symptoms of stress in young children may be difficult to distinguish from symptoms of minor illness. Be alert for signs of irritability, sleeping, toileting or eating difficulties, fearfulness, difficulties adapting to change in routine and clinginess, or use of key words such as "sad" or "afraid." As children get older, their responses to stress may include more attention-seeking behaviors, mood changes, avoidance of certain activities, isolation (such as the adolescent who retreats more and more to his or her room), school refusal or changes in the quality of schoolwork, sleeping difficulties and physical complaints (headache, stomachache). Seek help for your child if the symptoms persist or you are not able to identify the basis for these concerns. Your school psychologist, social worker, counselor or family physician can help locate appropriate resources.

Post-traumatic Stress Disorder: Children who experience overwhelming stress may develop Post-traumatic Stress Disorder (PTSD). PTSD refers to stress resulting from a specific incident: an incident severe enough to cause profound damage to an individual's ability to cope in everyday life, especially in those parts of everyday life that remind the person of the traumatic incident. Although the information in this handout may be of some help to people who suffer from PTSD, such individuals are advised to consult with a qualified professional for more specific evaluation and treatment to diminish the effects of the incident.

What Can I Do as a Parent?

Do not place undue expectations on your child. We all want our children to be successful, and we should have expectations for their behavior and performance. But when stress starts to show itself, it may be time to question if our expectations are too high.

Listen to your child when he or she describes stressful events or situations. Being a good listener will, first of all, reassure your child that you are there with love and support. Moreover, it will help you to better understand how you can help.

Teach your child good problem-solving skills. The feeling that we have too much to do in the amount of time available to us is a frequent cause of stress. When overburdened, we have difficulty seeing how to get ourselves out of the jam we're in. Help your child learn to break big problems into smaller ones that can be dealt with one at a time. Talk with them about how you have handled stressful situations.

Rehearse stressful situations. If speaking in front of a group or making a phone call to an adult is a cause for stress, it can be helpful to talk through the event with your child. Discuss how he or she wants the event to take place, and then go through the situation together in a "trial run." The practice is good, and possible difficulties can be "problem solved" together.

Be aware of "irrational thinking" patterns. Sometimes we can overhear our children "thinking aloud" with sentences like "I have to get this done or my friends are going to be mad," or "If I don't do this extra assignment, I'll never get into college." More frequently, only the first part of the sentence is there: "I have to do what the other kids are doing," "I shouldn't really be reading this novel just for fun right now," or "I need to get this whole list of things finished right now." Often hidden behind such thoughts is the unfounded belief that "if I don't live up to my teacher's expectations, I'll never be a success in life," or "if friends get mad at me, then that confirms that I'm not a good person." And, deep down, these "if...then" statements frequently mask core beliefs that people accept as true, even if they have never questioned them logically. These are beliefs like "I'm not a very loveable person," or "the world is a cruel place, and the only way to survive is by doing everything perfectly." If you become aware of harmful beliefs, help your child look at life, and him or herself, more realistically and more positively.

Relaxation/Visualization. There are a number of good relaxation tapes on the market, but all of them emphasize the importance of sitting or lying down and breathing slowly from deep in the stomach, rather than breathing where the shoulders or chest is in motion. A frequently-used visualization technique is that of relaxing (as above), and then imagining one self in a "favorite place" — a place that is warm and inviting, comfortable and beautiful. Relaxation techniques are useful for diminishing the feeling of stress, but they do little to keep stress from reoccurring. Relaxation can be especially effective when used in conjunction with the rehearsal of a stressful situation before it occurs. Some children might need professional assistance to learn effective relaxation techniques. Also, remember that for children as well as adults, exercise is not only a good way to "relax" but a good way to reduce both the physical and emotional "baggage" of stress!

Resources

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Stress in Children

A Handout for Teachers

by David Streight, Portland OR
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Background

Stress is a feeling of discomfort that is experienced somewhat differently by children and adults and from one individual to another. Our world is full of situations and events that cause stress — unemployment, marital tension, death of a parent or sibling, serious illness or injury, unexpected bills, etc. Particularly for school children, stressful events might include retention, poor grades, tests, schedule changes, etc. Additionally, stressful events outside of school — parents' divorce, abuse or neglect, poverty or community violence can impact student behavior and performance.

Even positive events can create a degree of stress — such as moving to a new home, starting high school, a new baby in the family, etc. Although a certain amount of stress is good, life today presents most of us with more stress than we want or need. The age of the computer, of instant information, of instant evaluation of our actions, rather than making life easier — as we always thought it would — has added to the expectations that others have of us or that we have of ourselves. With a little more time, we feel that we can always do "just a little bit more."

It is important to distinguish daily life "hassles" from significant stress. Adults and children experience such common hassles as waiting in line (at the teacher's desk, in the school lunch line), changes in daily routine, rescheduling classes, conflicts with friends, etc. Generally, children (as well as adults) learn strategies to effectively cope with these small hassles. Significant stressors such as death, serious illness or failing a test are more likely to catch children or adults unprepared to cope and result in serious consequences for the individual's physical and emotional well-being. However, while life's "hassles" generally have less negative consequences, the cumulative effect of many such "hassles" can be as detrimental as any single traumatic event. The perception of stress is also related to experience and development — what is stressful for one person may not even amount to a small hassle for another. The ability to evaluate stress level and to develop coping skills increases with age and cognitive development.

Our environment is stressful. But much of our stress is caused by our mental attitude in conjunction with the environment. Can you remember a time when a child's misbehavior nearly sent you "through the ceiling" in anger, even though on another day the same behavior from the same child might have bothered you very little? This is an example of the effect of our thoughts on our mood. Having to get something done for a sympathetic loved one is much less stressful than having to get the same task done for a demanding administrator or another individual who has power over us or whose expectations we feel we must meet. So it's not the situation that causes all the stress. Our beliefs about the situation are a big piece of the puzzle.

Although different individuals will find different events more or less stressful, stress in school-age children is usually caused by:

1. New, unfamiliar or unpredictable situations
2. Unclear expectations
3. Expectations of something unpleasant (e.g., pain, disciplinary action)
4. Fear of failure (socially or academically)
5. Major developmental "hurdles" (moving from elementary to middle school, graduation)

Symptoms of Stress

The effects of stress vary from one person to another and each person may develop unique symptoms or individual styles of handling stress. Some environments (e.g., homes, schools, etc.) are more stressful than others. Additionally, constitutional factors, including gender and temperament, play a significant role in how stress is perceived and handled. Stress is cumulative and progressive, and improved resources and coping skills are often necessary to reduce its ill effects.

There are generally three recognized stages of stress marked by phases of physical changes: alarm, resistance and exhaustion. In the first stage of stress, the body goes into "red alert" — with an increase in heart rate and breathing as the individual considers a course of action. This is followed by "resistance" where the body attempts to slow down and return to "normal." If the stressful event continues or if the individual is unable to adapt to the situation, exhaustion may follow.

Symptoms of stress in children: Symptoms of stress in preschool and young elementary children may be difficult to distinguish from symptoms of minor illness. Be alert for signs of irritability, nervousness, inattention, fearfulness, difficulties adapting to change in routine, clinginess, use of key words such as "sad" or "afraid." As children get older, their responses to stress may include more attention-seeking behaviors, mood changes, isolation from peers, school refusal or changes in the quality of schoolwork, and physical complaints (headache, stomachache). Stress is often a frequent factor in short tempers on the playground, fights in the lunchroom, or avoidance of classroom activities or school in general. If the symptoms persist or you are not able to identify the basis for these concerns, be sure to contact the child's parent to determine if similar symptoms have been observed at home or if there has been a recent change or traumatic event. Your school's psychologist, social worker or counselor can help locate appropriate resources.

Post-traumatic Stress Disorder (PTSD): Children who experience sudden or intense levels of stress may develop Post-traumatic Stress Disorder (PTSD). PTSD refers to stress develops from a specific incident: an incident severe enough to cause profound damage to an individual's ability to cope in everyday life, especially in those parts of everyday life that remind the person of the traumatic incident. Children whom you believe to be suffering from PTSD should always be referred to a counselor or school psychologist.

What Can I Do as a Teacher?

Look for those children who appear to have unrealistic expectations placed on them from home or elsewhere. All parents want their children to be successful, and we should have expectations for children's behavior and performance. But when stress starts to show itself, a discussion with parents about your observations may be in order.

Listen to the children in your class when they describe stressful events or situations. Being a good listener will, first of all, reassure them that you are there for support. Moreover, it will help you to better understand how you can help.

Teach children good problem-solving skills. The feeling that we have too much to do in the amount of time available to us is a frequent cause of stress. When overburdened, we have difficulty seeing how to get ourselves out of the jam we're in. You can help children learn to break big problems into smaller ones that can be dealt with one at a time.

Rehearse stressful situations. Children, alone or in groups, can rehearse going through certain stressful situations, like making phone calls to adults they don't know, or doing a job interview. Have children visualize how they would like the event to take place, and then go through the situation in class in a "trial run." The practice is beneficial, and possible difficulties can be "problem solved" before the actual event takes place.

Be aware of "irrational thinking" patterns. Sometimes we can overhear our students "thinking aloud" with sentences like "I have to get this done or my friends are going to be mad," or "If I don't do this extra assignment, I'll never get into college." More frequently, only the first part of the sentence is there: "I have to do what the other kids are doing," "I shouldn't really be reading this novel just for fun right now," or "I need to get this whole list of things finished right now." Often hidden behind such thoughts is the unfounded belief that "if I don't live up to my teacher's expectations, I'll never be a success in life," or "if friends get mad at me, then that confirms that I'm not a good person." And, deep down, these "if…then" statements frequently mask core beliefs that people accept as true, even if they have never questioned them logically. These are beliefs like "I'm not a very loveable person," or "the world is a cruel place, and the only way to survive is by doing everything perfectly." If you become aware of harmful beliefs, help the student look at life, and him or herself, more realistically and more positively.

Relaxation/Visualization. There are a number of good relaxation tapes on the market, but all of them emphasize the importance of sitting or lying down and breathing slowly from deep in the stomach, rather than breathing where the shoulders or chest is in motion. A frequently-used visualization technique is that of relaxing (as above), and then imagining one self in a "favorite place" — a place that is warm and inviting, comfortable and beautiful. Relaxation techniques are useful for diminishing the feeling of stress, but they do little to keep stress from reoccurring. Relaxation can be especially effective when used in conjunction with the rehearsal of a stressful situation before it occurs. Sometimes school mental health professionals teach relaxation skills to individual students or small groups. Talk to your school psychologist or counselor about the availability or appropriateness of relaxation training.

Resources

Charlesworth, E.A. & Nathan, R.G. (1984). *Stress Management: A comprehensive guide to wellness.* New York: Ballantine.

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Foreman, S.G. (1993). *Coping skills interventions for children and adolescents.* San Francisco: Jossey- Bass.

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Hess & Copeland, E. (1997). Children and stress. In G.Bear, K.Minke & A.Thomas (Eds.), *Children's needs II: Development, problems and alternatives* (pp.293-303). Bethesda, MD: National Association of School Psychologists.

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Temperament

Information for Parents

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Background

Temperament refers to a basic style in how an individual approaches and responds to people and situations. Every child has a personal set of temperament characteristics that are evident at an early age. Temperament belongs to the child and resists change. However, the expression of the temperament is modified by interactions with other people and by events in the child's life. A child's temperament is expressed through his/her reactions to situations as well as the child's interests and choices. Other people, in turn, respond to the child's behaviors. Thus, temperament shapes the child's day to day experiences. It is helpful for parents and teachers to understand the child's temperamental style to maximize the goodness-of-fit between the child's characteristics and situational demands. As the child matures, insight into his or her own temperament is also very helpful in learning to regulate his/her own actions and reactions.

Development

As children develop, their temperament influences how they interact with their surroundings. Broad dimensions of temperament can be described by examining the three clusters of characteristics described below.

Emotional Reactivity — Children vary in their mood and in their emotional responses to various situations. Some children show more joyful, friendly emotions, while others tend to express worry, anger or fear. The amount of stimulation needed to bring out an emotional response is determined by the sensitivity level of the child. Children differ in the intensity with which they customarily express emotion. A highly intense child may scream with anger in the same situation which would cause a low intense child merely to grumble or frown.

Coping — Children try to maintain a level of stimulation that is comfortable and allows them to cope most efficiently with their experiences. Maintaining this comfortable level of stimulation is accomplished by approaching or avoiding unfamiliar situations. Overstimulation is prevented by withdrawing from threatening situations. On the other hand, stimulation can be increased by exploring and by approaching new people and challenging situations. Children differ in their ability to handle new and different situations that they cannot avoid. Some children take a long time to get used to unfamiliar situations or changes in routine; others adapt more easily. Some children will not back away from unpleasant situations either because they don't know how or they are invested in long-term goals and tolerate the discomfort.

Task Orientation — Three temperament aspects are related to how long children stick with ongoing tasks, especially when they didn't choose them. These are:

- **Distractibility:** Distractibility is the degree to which sights and sounds around children interfere with ongoing activity. Noises in a classroom are a good example of something which bothers some children and not others. A highly distractible child is greatly influenced by environmental sights and sounds and seems to be captured by the strongest stimulus present (e.g., the TV or computer).

- **Persistence:** Persistence is the continuation of an activity even when there are other possible activities or requests to stop an ongoing activity. Another name for it is attention span. A persistent child will return to a task even after an interruption. Sometimes a highly persistent child may protest when a parent requests a change in activity. Negative persistence (not taking "no" for an answer) is not the same as task persistence or sticking to ones principles.
- **Activity Level:** Activity Level is the amount of physical activity displayed by a child. Some children are very active and seem to run from one activity to another without stopping. Other children are more content with quiet activities. Children with a high activity level are sometimes also very distractible and have a low level of persistence. These children have difficulty sitting still and concentrating in the classroom. Often, underachievers have this combination of high distractibility, low persistence and high activity level.

It is incorrect too assume that children who are at the extreme ends of one or more of the temperamental characteristics described above are not normal. However, some children are at greater risk of developing emotional problems because the expectations of parents, teachers and peers do not match their temperamental tendencies. These children are often described as "difficult" because those who care for the child find him/her difficult to manage. As a result, the caregivers are frequently frustrated or angry. Such a child senses that others disapprove of his/her behavior. However, the child typically cannot change the behavior even with great efforts. When the characteristics of the child do not match the expectations of others, problems may arise in the child's development.

What Can I Do as a Parent?

It is very important to make accommodations for a child with behavior problems that are due to temperament. In managing a child with a difficult temperament, the goal is not to accept all of the youngster's behaviors but to reduce or eliminate the adverse impact of temperament. Just as one would not expect a child with a full bladder to sit quietly for a long time, one would not require an active child to do the same. However, if the child is displaying behavior that is primarily manipulative, consequences will need to be changed. Goals for parents who are trying to manage the behavior of a child with a difficult temperament might include:

- Minimizing demands or expectations that are substantially at odds with the child's temperament.
- Enforcing schedules and activities that will alleviate the undesirable effects of the child's temperament on development.
- Encouraging the child to learn self-understanding and ways of coping with temperamental difficulties.

The following techniques are suggested for accomplishing the above goals:

Structure — Despite detailed explanations of what is expected, some children cannot monitor their own behavior without supervision and guidance. For example, they have difficulty remembering to bring school books home and working independently. Positive methods of helping the child are more effective than constantly reprimanding the child for irresponsibility. It is beneficial to supervise the behavior of a distractible child by giving him/her frequent (but gentle) reminders, helping to organize homework, making lists with the child, and praising success.

Prevention — Understanding the child's temperament and anticipating the situations in which difficulties will arise can help parents avoid confrontations and minimize conflict. An active, distractible child may expend so much effort struggling to pay attention in school that parents may wish to ease up on their expectations at home. Also, a persistent child who finds it difficult to stop an activity may be given a few minutes notice so he/she can gradually terminate the ongoing activity. Changes in routine for a child who adapts poorly can be planned to allow time for adjustment.

Preparation — When parents cannot modify the environment or their demands to suit the child's needs, they can help prepare the child for upcoming, stressful events. Children who adapt poorly do not like surprises and welcome being able to anticipate changes of routine. Such children benefit from being told of upcoming events such as what will happen on a trip or when company will arrive. Parents and children may even rehearse events such as an anticipated visit to the doctor's office.

Teaching coping skills and self-understanding — When children are old enough, discussion about their sensitivities may be helpful. Parents can label the child's emotional reactions with a nonjudgmental attitude and convey understanding. Eventually, children can learn to label their own emotional reactions and verbalize their needs.

Acceptance — Parents may feel that it is their duty to attempt to change a child's irritating behavior. However, there is little that can be done to change negative mood or intense emotional expression. In fact, it is damaging to require a child to "cheer up" because such requests convey the feeling that the child's natural mood is unacceptable. Children whose innate tendencies are constantly challenged may not develop positive self-esteem and in the long run may have more difficulties coping with their own problematic temperamental characteristics.

Building relationships — parents are human so irritations caused by some temperamental traits are inevitable. Sometimes it takes a great deal of patience and perseverance to promote a solid relationship with a difficult child. Yet, criticism and hostility should not pervade the relationship. Parents can try to make the most of situations that are pleasant. Enjoyable activities in which a child's temperament is an asset should be planned. Parents can be alert for situations that bring out the best in a child. Building a positive relationship between parent and child helps to manage the difficult temperamental qualities while solidifying the bonds between parent and child.

Resources

Carey, W. B., & McDevitt, S. C. (1995). *Coping with children's temperament.* New York: Basic Books.

Kurcinka, M. (1991). *Raising your spirited child: A guide for parents whose child is more intense, sensitive, perceptive, persistent, energetic.* Harper Perennial.

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Trauma and Children

A Parent Handout for Helping Children Heal

by Philip J. Lazarus, Ph.D.
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Background

Every parent at one time has worried about harm befalling their children. When trauma to children occurs, the territory of everyday life becomes frightening and unfamiliar not only for children but parents as well. Parents may find themselves overcome with anxiety and fear. Trauma may send a shockwave to the system and parents may respond with a wide range of feelings. These feelings may include a sense of disbelief, helplessness, isolation, despair, or horror. Parents may try to make sense out of a senseless act. Who can prepare for their children being physically or sexually assaulted, kidnaped, mugged, robbed or involved in a severe automobile accident? Who can prepare for children being diagnosed with a life threatening illness or experiencing a natural or man-made disaster?

Traumas typically occur suddenly, often leaving children little or no time to prepare physically or emotionally. Traumas are unpredictable and outside what is to be expected in children's lives. During a trauma, children experience intense fear, horror or helplessness. Typical methods of coping no longer work. Following trauma, children require extra support and need to learn new coping strategies.

Parents can be instrumental in their children's recovery. Therefore, helping children recover from a trauma is a family matter. Parents need to take the lead and model positive coping. Yet parents themselves may require extra information, support and resources to assist their children. Some first steps that parents can take are to understand the impact and symptoms of trauma and how to help in the aftermath. This handout provides this information.

The Impact of Trauma

Trauma can change the way children view their world. Assumptions about safety and security are now challenged. Children's reactions will depend upon the severity of the trauma, their personality makeup, their characteristic coping style and the availability of support. It is common for children to regress both behaviorally and academically following a trauma. A constructive way to view the situation is that they are normal children in an abnormal circumstance.

It is natural for children to first experience some sort of *denial*. For example, children may insist upon returning to a house that has been destroyed. *Fears, worries or nightmares* are common following a trauma. *Sleep disturbances or eating difficulties* may happen. Also children may begin to *regress emotionally* or act younger than their chronological age. They also may become more *clinging, unhappy and needy of parental attention and comfort*. Feelings of *irritability, anger, sadness or guilt* may often emerge. *Somatic complaints* such as headaches, stomachaches or sweating are not unusual. Some *loss of interest in school and poor concentration* are some other common reactions.

Symptoms Associated with Post Traumatic Stress Disorder

Following a trauma children may experience some of the symptoms of Post Traumatic Stress Disorder (PTSD). The main symptoms are as follows:

Re-experiencing of the trauma during play or dreams.

For example, children may:

- Repeatedly act out what happened when playing with toys
- Have many distressing dreams about the trauma

- Be distressed when exposed to events that resemble the trauma or at the anniversary of the trauma
- Act or feel as if the trauma is happening again

Avoidance of reminders of the trauma and general numbness to all emotional topics.
For example, children may:

- Avoid all activities that remind them of the trauma
- Withdraw from other people
- Have difficulty feeling positive emotions

Increased "arousal" symptoms.

For example, children may:

- Have difficulty falling or staying asleep
- Be irritable or quick to anger
- Have difficulty concentrating
- Startle more easily

What Can I Do as a Parent Following a Trauma?

- ***Establish a sense of safety and security.*** It is essential that children feel protected, safe and secure in the aftermath of a trauma. Ensure that all basic needs are met, including love, care and physical closeness. Spend extra time to let children know that someone will nurture and protect them. Children will need a lot of comforting and reassurance.

- ***Listen actively to your children.*** Seek first to understand before trying to be understood. Parents may underestimate the extent of the trauma experienced by their children. It is often not as important what you say, but that you listen with empathy and patience. In some instances your children may be reluctant to initiate conversations about trauma. If so, it may be helpful to ask them what they think other children felt or thought about the event. Also, it may be easier for children to tell what happened (e.g., what they saw, heard, smelled, physically felt) before they can discuss their feelings about the trauma. In other instances, children will want to tell their parents the story of the trauma over and over. Retelling is part of the healing process. Children need to tell their stories and have their parents listen, again and again to each and every agonizing detail.

- ***Help your children express all their emotions.*** It is important to talk to your children about the tragedy — to address the suddenness and irrationality of the disaster. Reenactment and play about the trauma should be encouraged. It is helpful to ensure that children have time to paint, draw or write about the event. Provide toys that may enable children to work through the trauma. Examples may include such items as a toy fire engine, ambulances, fire extinguisher, doctor kit, etc. for a girl injured in a fire. Imagining alternate endings to the disaster may help empower your children and allow them to feel less helpless in the aftermath of a tragedy.

- ***Validate your childrens' feelings.*** Help children understand that following a trauma all feelings are acceptable. Children will probably experience a myriad of feelings which could include shame, rage, anger, sadness, guilt, pain, isolation, loneliness and fear. Help your children understand that what they are experiencing is *normal* and to be expected.

- ***Allow your children the opportunity to regress as necessary.*** This is important so that they may "emotionally regroup". For example, your children may request to sleep in your bed with the lights on or you may need to drive your children to school. Previously developed skills may seem to disappear or deteriorate. Bed wetting or thumb sucking may occur. Aggression and anger may emerge in a previously non-aggressive child. Be patient and tolerant and never ridicule. Remember that most regression following a trauma is temporary.

- ***Help children clear up misconceptions.*** Help correct misunderstandings regarding the cause or nature of the trauma, especially those that relate to inappropriate guilt, shame, embarrassment or fear. (Examples may be " I should have been able to save my brother from the car wreck." "God struck my sister dead because God was angry at her." "My father died of cancer and I will catch it from him.")

- ***Educate yourself about trauma and crisis.*** The more you know about trauma, the more empowered you may feel. To help educate yourself, consider setting up a conference with the school psychologist or mental health professional in your school. A good place to start is by reading the text listed below under "Resource for Parents."

- ***Help predict and prepare.*** If your children need to go to a funeral or deal with surgery, carefully explain what will happen each step of the way. Allow your children to ask all kinds of questions. If they need to appear in court, explain what they will see, hear, do, etc.

- ***Arrange support for yourself and your family as necessary.*** Consult with your clergy, rabbi, physician and friends as necessary. You may need extra emotional, religious, medical and/or psychological support. If possible take appropriate time for recreational or pleasurable experiences with your children to establish a sense of normalcy and continuity.

- ***Communicate with the school and staff about what occurred.*** Most teachers will be understanding and helpful if they know that children had a traumatic experience. Teachers may be able to provide additional support both educationally and emotionally. They can also provide information to doctors or therapists or alert you to troublesome behaviors they observe.

- ***Affirm that your children are capable of coping and healing in the aftermath of a trauma.*** Plant "emotional seeds" that express confidence in your children's ability to heal. Remember the messages that you give your children have incredible power.

- ***Seek professional assistance for your children and family as necessary.*** When seeking help, make sure the professional has experience with children and has treated crisis and trauma. Feel free to discuss with the therapist all your concerns and all aspects of treatment. If your children are experiencing the symptoms of PTSD, then therapy may be warranted.

What Can I Say as a Parent Following a Trauma?

- Sometimes knowing exactly what to say is difficult. However, your emotional expression of love and concern is more important than words. Just saying "This is very hard for us" can lead to emotional relief and understanding.

- Always be honest with your children about what has happened and what may occur. Remember that following a trauma, children may lose a sense of trust about the safety and security of the world. Therefore, honesty is essential so your children can maintain a sense of trust.

- Respect your children's fears. Children can not be helped by trying to argue them out of their fears by appeals to bravery or reason. What is most helpful is an approach that says "I know you are feeling frightened of — — — — — now." This can be followed by an offer of assistance and support by saying, "Let's see what we can do to make this less scary for you."

- Make sure that your children know that your are aware of the seriousness of the situation. Allow your children to cry. Saying to your children "Don't cry, everything will be fine" denies the seriousness of the situation.

- Try to recognize your children's feelings and put them into words. For example, if a child's close friend died in an automobile accident, you might say to your child "You are sad and angry that your friend was killed. I know that you must miss him very much." Or if a child feels overwhelmed by fears in the aftermath of a hurricane, you may say, "I know that you are frightened, but we have a plan to protect us if another hurricane occurs."

What Should I Do If I Believe My Child May Be Suffering from PTSD?

Consult with your local school psychologist or contact a mental health professional who has experience in this area such as a psychiatrist, psychologist or mental health counselor. Your school psychologist or pediatrician may direct you to the appropriate resources.

What Type of Therapy is Recommended for Traumatized Children?

A variety of methods may be used depending on the orientation of a particular therapist. Very different approaches to the same problem can be equally effective when undertaken by an insightful and skilled professional. Approaches may include individual, group or family therapy. Therapists often use play, art and drama methods in their treatment as well as "cognitive-behavioral" approaches, which help children reinterpret events and feelings in a more positive way , or in some cases they might use clinical hypnosis. As part of the therapy experience, children will be guided to reprocess the trauma in a safe and supportive environment. In some instances medication may be used to control severe anxiety, depression or sleeplessness. However, medication should not be used as a substitute for psychotherapy for traumatized children.

If I Seek Therapeutic Services for My Children, What Will be the Goals of Therapy?

The goals of therapy with traumatized children should include:

- Gaining a sense of mastery and control over one's life
- The safe expression and release of feelings
- Relief of painful symptoms and post traumatic behaviors
- Minimizing the scars of trauma
- Corrections of any misunderstandings and self-blame
- Restoration of hope regarding the future
- Establishing a renewed sense of trust in oneself and the world
- Developing perspective and distance regarding the trauma

Summary

Helping children recover from trauma is a family matter. It is important to maintain an open discussion of the trauma and recognize the feelings of all family members. Focus on the immediate needs of the children, and take a one-day-at-a-time approach. Find and use support systems outside of the family. Always maintain a positive image of your children as healers and survivors.

Resource for Parents

Monahon, C. (1993). *Children and trauma: A parent's guide to helping children heal.* New York: Lexington Books.

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Anger Management for Young Children

A Handout for Parents

by Beth M. Levy
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Behavior Problems and Solutions

Background

Anger is a natural emotion experienced by all living creatures. Animals and humans react and display behaviors when angry, and although humans can also use language to communicate feelings, wants and desires, they often use actions and behaviors instead. Some of these angry feelings and responses are inborn; however, adults also teach children how to respond to emotions. Children learn how to react and handle different feelings from watching parents, friends and teachers around them.

Anger can be a good emotion because it tells us if something is not right, or if we are in danger. Learning how and when to respond to the different feelings of anger is the lesson we need to teach our children. The best way to teach children to handle their anger is by modeling appropriate behaviors, and this is especially important for young children, who are learning how to associate new words with their feelings.

Development

Typically, children direct their aggressive behaviors toward other children more often than toward adults. Children display their anger inappropriately because they do not have good coping strategies. Children do not understand how situations or actions can evoke angry feelings. Something triggers a reaction in the child and they do not know how to respond. Young children are not yet intellectually able to correctly label emotions and to respond in a socially desired manner. They get physical (i.e., pushing, hitting, biting, kicking and screaming) because their language has not yet fully developed and they react with inborn responses.

As children grow, understanding the typical behaviors associated with each developmental (age) stage is helpful to parents. Although these stages do not match every child perfectly, as they do not take into account individual temperament or environmental factors, they can be useful guidelines to follow.

A Two-Year-Old Child: Two-year-olds have difficulty making decisions. They want to know everything. "W*hy*?" Becomes the two-year-old's ultimate question. During this stage of development there continues to be little, if any, sharing. By two and a half, children start to display intense and often violent emotions. They want everything, especially what they cannot have. Children at this stage express strong feelings for what they desire and will do whatever they need to in order to obtain the desired object.

A Three-Year-Old Child: The child at three starts feeling more independent and more comfortable sharing with other children. At the same time, the three-year-old frequently feels scared in new situations and as a result strives for control again. Their assertiveness is shown through verbal threats, such as: "You are stupid" or "I hate you."

A Four-Year-Old Child: At four a child will do anything if provoked. Kicking, spitting and even running away is often seen when the child does not get his way. While they need boundaries, the four-year-old enjoys pushing the limits. Verbal aggressiveness increases with four-year-old children by more name-calling.

A Five-Year-Old Child: Five-year-old children want to be "good" and would rather stay with what is comfortable than try new things. Children at this age often exhibit some tantrums and sulking when they become upset.

A Six-Year-Old Child: When you are around a six- year-old, you never know what will happen because they rarely make up their mind. The six-year-old is striving for independence and displays an intense need to be first and the best. This causes much anxiety for them. They also want to have everyone's attention. They become verbally and physically aggressive and use such phrases as: "Make me" or "No, I'm not going to do it." By teasing and bullying, the six-year-old can be very loud and bossy.

A Seven-Year-Old Child: Seven-year-old children tend to withdraw when things become difficult and to look inward at themselves. They start thinking about the world around them. Worry becomes a major preoccupation, and they show increased concern with what is fair verses what is unfair.

An Eight-Year-Old Child: The eight-year-old child is inquisitive — interested in everything that is going on. Friction and jealousy frequently arise among siblings because children at this age still want their mother's attention and will rival with siblings to get it. It is very easy to hurt the feelings of an eight-year- old.

A Nine-Year-Old Child: Nine-year-old children do not want to be told what to do by their parents. They resent these directions and often rebel. These children can often be found fighting, complaining, criticizing and ignoring their parents.

What Can I Do as a Parent?

Before you can help your children deal with their anger, you must first explore your own feelings of anger and the way in which you deal with these feelings. Children learn from observing their parents. It is important that parents be aware that their method of dealing with anger is observed and will be imitated and learned by their children. Furthermore, understanding the typical developmental behaviors of children helps parents to know which behaviors are not typical and might need looking into. Here are some things to try:

Positive reinforcement: This is a very effective method for teaching children desired behaviors because children strive for attention. Focus on your child's good behaviors, instead of focusing on their bad behaviors. Reward your child often with a small treat or special attention for every short period of time that your child behaves appropriately. Be consistent because your child needs to clearly understand what is expected of him. If you need assistance creating a behavior plan, contact your school psychologist.

Help children understand and express feelings: When voices and tantrums become louder and louder, tell the child that you will wait until they use a calm voice. You may also validate their anger while asking what you can do to help, such as "I see that you are angry, what can I do to help?" Children may not always get what they want, but you are teaching them that their feelings matter. You also teach them that there are more acceptable ways to achieve their desired goal or to obtain a desired object without anger.

Help children learn problem solving skills: Role-playing different solutions and teaching problem solving techniques will also be beneficial to your child because you can demonstrate positive, non-violent ways to resolve conflict.

Self talk and relaxation: By school age, positive self talk can help your child to talk himself down from an angry outburst. Self talk statements such as, "I can handle this", "I'm okay, just stay calm", etc., are useful ways to help children control their anger at times when they especially need to remain calm. Teach them relaxation techniques such as: count to 10 before taking action, or taking several deep breaths when faced with difficult or anger-provoking situations. When teaching your child new techniques, keep them developmentally appropriate.

Parents can play a positive role by helping their children deal with anger. Parents who use positive approaches and modeling techniques will enable their children to grow emotionally strong and able to deal with the difficult situations they will face in the course of everyday life.

Some children inappropriately display anger because they have not yet learned more effective coping strategies. There are other children who may become violently angry or who may display hazardous behaviors that are dangerous to themselves and others. If there is an increase in your child's anger, determine whether any significant changes have occurred which might be upsetting your child. If your child is displaying severely violent or dangerous behaviors, it is strongly recommended that you seek additional assistance from a school psychologist or a pediatrician.

Resources for Parents

Bilodeau, L. (1992). *The anger workbook.* Minneapolis: CompCare Publishers.

Clark, L. (1996). *SOS! Help for parents* (2nd edition). Parents Press.

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Severe, S. (1996). *How to behave so your children will, too!* Greentree Publishing.

Resources for Elementary or Preschool Children

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Anger Management for Young Children

A Handout for Teachers

by Beth M. Levy
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Background

Today, classrooms are filled with angry students. Anger is a basic emotion that everyone experiences, yet how we express anger depends on how we have learned to deal with it. Many children who act out angry and aggressive behaviors do so as a result of not having alternative solutions. Different temperamental and environmental factors also play a role in children's displays of emotion. Angry behaviors may be indicators of other factors, such as an undiagnosed learning disability, emotional problems, dealing with parents' divorce, or other changes occurring in the student's life. Important differences between gender show that girls' conflicts are typically related to their concerns with belonging or fitting in with peers, while boys' conflicts tend to be over objects or physical attacks. These differences can also affect how students respond to anger-provoking situations. Girls who want to belong to a group of peers may use different strategies than would a boy in order to retrieve a toy at recess.

Young children tend to relate emotions to a situation. When that situation is removed, so is that emotion, whereas older children continue to hold their emotions over time regardless if that situation is present. Conflicts between many preschool-age children are related to objects, territory or access to privileges. When trying to help an angry child, it is important to take into account their temperament, environmental situation and stage of development. For many children, it appears that they need to be taught effective strategies for handling their anger.

Development

Preschool students are typically driven to get their basic needs met. They will do anything to get what they want such as kicking, hitting or spitting. Most of the conflicts experienced by preschoolers are over objects or possessions. For some preschool children, this is their first experience playing in a group. Throughout their schooling, there is an increase in group play in which students need to learn to share, compromise and respect other students' ideas and wishes. Also as children grow, they begin to recognize others as separate individuals. As a result, they stop directing their anger toward objects and focus their aggressive behaviors toward others. Often young children have learned to use these aggressive behaviors by watching adults.

The elementary-age students often have difficulty dealing with their anger because they are unaware of alternative options for handling conflict. Many students resort to physically aggressive methods in order to solve their conflict. As children develop through elementary school, they become increasingly more verbally aggressive when dealing with conflicts. Some of these students use their physical or verbal aggression because it is what is familiar to them and it is how they have learned to achieve their goals. Teachers have the opportunity and the ability to promote alternative strategies for handling conflicts in the classroom.

What Can I Do as a Teacher?

As a teacher, you can teach your students adequate social skills by first designing an environment that promotes positive and alternative options for handling conflict. Specific and effective classroom rules and guidelines are essential for students to understand what is expected of them. It is very important to have your expectations clearly defined and to have specific consequences stated if those expectations are not met. A plan needs to be developed before students walk into your classroom in the beginning of the year, and it needs to be a part of your everyday activities. Positive reinforcement (praise) of the desired classroom behaviors on a regular basis will show students the behaviors that will receive positive attention. Again, this reinforcement by the teacher needs to start on the first day of school in order for the expectations to be known to students. There are students who will continue to act out in order to receive negative attention; Therefore, it is important to examine what reward or pleasure they receive from their inappropriate behavior. Do they get to spend extra time or individual time with the teacher? Do they get out of doing their work? Do they get the other children watching them? If you answered yes to any of these questions, then you may want to think about changing how you handle students' inappropriate behavior. For example, you could isolate the child from the group for a set amount of time. This would send the message that this behavior is not appropriate and the child would miss the fun activity in which everyone else is participating. You could also ignore the child's negative behaviors; however it may not be safe to ignore these behaviors depending on the situation. You can praise and promote the appropriate behaviors of other children in the class, thus creating positive peer role models. It is also important for teachers to remain calm when dealing with an angry student. Some students look for an angry response from the teacher in the hopes of getting into a struggle for control.

It might be beneficial to teach your class problem solving techniques or role play various options of conflict situations in the beginning of the year. An effective method to help students decrease their angry behaviors is by providing positive self-statements ("I am okay", "I can go to another activity") when teaching alternative conflict solutions. Implementing these strategies early in the year will help prevent the inappropriate behaviors. Again, by teaching such techniques, you are providing positive alternative ways for students to handle situations. Self talk statements ("I can handle this" or "I can calm down now") are also effective in controlling anger. By using self talk, students can change their unrealistic angry perceptions by talking themselves down into a more relaxed state. This will give students the opportunity to calmly examine the situation rather than look at it from an emotionally charged angry state. Relaxation techniques, such as counting to 10 or taking deep breaths, can also teach children to help reduce the physical arousal created by their angry thoughts.

Teachers can help students learn to control their anger. Modeling, new conflict resolution strategies, problem solving techniques, setting up clearly defined classroom rules and positive reinforcements are some of the many preventative interventions teachers can employ in their classrooms to assist all students in dealing with their emotions.

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Classroom Management Skills

A Handout for Teachers

by Gretchen Fury, Michelle Jetzer and Todd Lamb
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Overview

Over the past twenty years, there has been a substantial increase in research pertaining to effective teaching. The common theme within this literature is that effective teachers are professionals who can make a difference in the lives of students. The literature addresses the attitudes, teaching skills and student learning experiences that are associated with effective teaching. The teaching skills of the effective teacher are characterized by (a) a concern for the use of teacher and student time, (b) an emphasis on the curriculum, (c) the introduction of new material in small steps with guided practice, (d) the monitoring of student progress, (e) the attention to skills and frequent reviewing to ensure that content is successfully introduced, and (f) a strong set of classroom management skills that involve a flexible instructional program and active teacher involvement with all students. This handout addresses effective classroom management skills.

Definition

Effective classroom management has been defined as the provision of procedures necessary to establish and maintain an environment where instruction and learning can take place. The primary goal of effective classroom management is not the creation of an orderly environment or the reduction of misbehavior. The primary goal is student learning. Although the presence of order within a classroom does not always indicate high levels of learning, research does suggest that strategies that promote learning can help facilitate order within the classroom.

Effective classroom management is a positive aspect of teaching. It is creative; it creates both the best situation for the student to learn and the teacher to teach. There are three key dimensions to effective, positive classroom management: The *physical dimension* encompasses how to establish a classroom that is a safe and productive learning environment. The *instructional dimension* describes how to teach so that the students stay focused on learning. And finally, the *managerial* aspect examines the non-instructional routines that are basic to running a smooth classroom.

Students need to feel that they have some freedom of choice in their learning environment, but this must occur within the context of a structured classroom. Consequently, effective classroom management is prosocial. It promotes the growth of physical and emotional development within the context of a secure environment.

General Approaches to Classroom Management

Given that student learning is the primary goal of effective classroom management, it is essential to establish and maintain a strong level of instruction, specifically in areas such as time management, rule development and implementation, and behavioral interventions. The primary instructional tasks must be emphasized so that the teacher may avoid being distracted by student misbehavior. The effective teacher understands that the purpose of effective classroom management is not simply reducing misbehavior, but more importantly, it is *increasing appropriate behavior* so that an environment highly conducive to learning can be created.

The classroom rules lay the groundwork for successfully increasing appropriate behaviors. They need to be combined with the performance objectives of the class in order to play a preventive role. Rule implementations are not simply the introductions of new expectations, but rather a means for teachers to communicate an awareness of potential problems. They also provide teachers the opportunity to clarify the consequences for any rules broken. In many instances, teachers who have highly defined rules care very deeply about maintaining order in their classrooms and are able to demonstrate an ability to respond to broken rules. Likewise, the students will have an awareness of specific behaviors that the teachers are looking for and will be less likely to break the set rules.

No matter how well-defined the rules, there will always be occasion for some sort of intervention following a broken rule. The tendency for misbehavior is undoubtedly related to students' perceptions of the teacher as a manager. Since most misbehavior is initiated by only a few students, it is essential for the teacher to gain credibility with the class by knowing the times and types of tasks during which these specific students will misbehave. It is interesting to note that high ability students are more likely to misbehave during transitions and near the end of instructional sessions. Contrarily, low ability students are more likely to misbehave in the middle of an instructional session.

Interventions range from relatively unobtrusive signals, such as pointing to a student's work, eye contact, subtle gestures and proximity, to extremely disruptive actions. Short words can be effective if delivered quickly and without disrupting the lesson. Interventions that interrupt the flow of the lesson and invite negotiation or discussion at an inappropriate time can be counterproductive. Often it is possible to intervene by having the student answer a question pertaining to the lesson which will keep the class focused while making it known that the student's behavior is being observed. If the intervention cannot be handled quickly, rather than interrupt the flow of instruction, teachers should assign a task to keep the rest of the class engaged. This provides teachers the time to effectively deal with the problem and reduces the likelihood of an irrational, negative teacher response. However, interventions should be used sparingly since there is little research supporting a positive correlation between the frequency of interventions and student achievement.

Punishment and reprimands: Along with reducing the frequency of intervention, it is also important to reduce the frequency of reprimands and punishments. In some cases, negative teacher attention stimulates misbehavior. A cycle can easily be created whereby the teacher continues to reprimand more severely as the misbehavior perpetuates and nothing is gained except a further decrease in student learning. If reprimands are given, they should be contingent, specific and credible, addressing the specific action, not the person, as undesirable. Reprimands should be followed by a reason and a suggestion for more appropriate behavior. It is important that academic errors do not become confused with misbehavior as students should always be encouraged to do their best, but cannot always be correct. The problems associated with punishment only increase the importance of prevention and early intervention before misbehaviors become severe.

Encourage positive behavior: One of the most effective ways for teachers to reduce misbehavior is to encourage appropriate behavior. Praise can be useful when it is immediate, specifies the particulars of the accomplishment, shows spontaneity, attributes success to student effort and uses students' own prior accomplishments as the context for describing present accomplishments. Teachers can also clearly state positive behaviors that students should exhibit as opposed to making students guess the behaviors considered appropriate based on observed patterns of rewards and punishments. Such behaviors may include responding appropriately to academic requests or tasks, becoming involved in class activities and respecting others. Perhaps the most important type of appropriate behaviors are those that enhance student learning.

Classroom Strategies for Effective Behavior Management

A number of strategies will assist classroom teachers in managing an efficient classroom environment:

- Establish the rules of the classroom and consequences for breaking these rules on the first day of class. Have the rules posted throughout the classroom and consistently reinforce them.
- Provide a box to invite students to submit comments, questions, suggestions, or complaints about the class. This gives students a sense that their opinions are important to the teacher.
- Design a seating chart that separates the students with behavioral problems, but keeps them close to the teacher.
- Have assignments and the day's lesson posted for the students so they do not have to interrupt the teacher and ask what will be happening in the class.
- Establish a procedure for entering the classroom, and have the students practice this *everyday*. Engaging students in the first three minutes of class sets the tone for the remainder of the class.
- Prepare teaching materials in advance. By having all materials readily available, smooth transitions are likely, and there is less time for student restlessness and disruption.
- Use a variety of teaching techniques to prevent student boredom.
- Use sincere and positive reinforcement.
- Establish a positive, inviting classroom climate by preparing the instructional space:
  - Colorful posters and inspirational banners fill white space on walls
  - The room has plants and clean, comfortable furniture
  - The room is clean and orderly
  - Bulletin boards are colorful, age-appropriate and invite student participation
  - Student work is posted in the classroom and in the hallway outside of the classroom

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Classroom Rules: Promoting Competent Behavior of Tough Kids

by William R. Jenson, University of Utah
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Tough kids show up every year to test and perplex teachers. Typically these students show behavioral problems such as noncompliance, not being prepared to work, talking out, being out of their seats, poor social skills and disrupting the classroom (Morgan & Jenson, 1988; Sheridan, 1995; Walker, 1995). These behaviors can become so difficult that they are the leading reason that teachers leave education in the first two years of their careers (Rhode, Jenson, & Reavis, 1993). Rules and a simple management system can save teachers untold difficulty if they are designed correctly and implemented early in the academic year. School psychologists can be instrumental in helping teachers design these systems particularly as an August in-service before school starts.

Proactive strategies lead to the best and consistent management. The following Tough Kid Program first will focus on setting up classroom rules as a "package" of behaviors that represents a teacher's set of classroom expectations. Second, we will show simple steps for preplanning mild consequences for rule infractions by difficult students. Third, the program will show how to design a simple reward system for use in a classroom when students follow the classroom rules. Fourth, the program will give corrective steps for tough students who insist on breaking rules through the use of self-monitoring with teacher feedback (Jenson, Rhode, & Reavis, 1994).

Practical approaches that are time efficient, effective and serve teachers' expectations are critically needed. School psychologists can supply these approaches through consultation and direct interventions in the classroom. When these programs are designed to give students corrective feedback and include positive incentives, then the competencies of both teachers and students are served.

Rules as a Package of Expectations

Rules should be designed that are specific and represent what a teacher expects in a classroom. The basic steps for designing rules are:

1. Rules should be specific, observable (eye — see Classroom Rules chart), and measurable (ruler — see chart)
2. Rules should be limited to approximately six in number
3. Rules should be primarily positive
4. Rules should be specific (see Classroom Rules as a Package) rather than ambiguous (e.g., responsible, show respect, or be a good citizen)
5. Rules should reflect a teacher's common classroom expectations (e.g., compliance, being prepared, not talking out, being on time, in-class behavior and transition behaviors)

Preplanning Consequences: The What If Chart

Preplanning consequences for a Rules Chart is critical so that teachers are not left searching for consequences. Both mild reductive consequences for rule breaking and positive consequences (often forgotten by teachers) for following rules should be included (see What If Chart). Steps:

1. Select reductive consequences for *individual students* (right side of chart) who break rules.
2. These consequences for rule breaking should be mild, not severe, and arranged in an increasing hierarchy (i.e., warning about breaking the rule, writing name in discipline book, having to wait 30 seconds after bell rings to leave, having 10 minutes shaved from recess, etc.).

3. Avoid using severe or ultimate consequences on the rule chart. You can list crisis or emergency procedures in the crisis section of the What If Chart (see lower right section) for students who bring weapons or controlled substances, or physically attack a teacher. For example, the student will be removed from the classroom and placed in in-school suspension until a parent conference is held.
4. On the left side of the What If Chart, list in a decreasing hierarchy of positive consequences what the *whole class* earns for not breaking rules. For example, set a goal of the total number of rules that you will allow to be broken and still earn positive consequences for the whole classroom and write it in the bottom square of the What If Chart (e.g., four rules broken) .
5. For example, if no rules are broken by the whole class, they will receive a Mystery Motivator at the end of the day. A Mystery Motivator is a positive consequence (unknown to the students) written on a piece of paper and placed in an envelope at the bottom of the What If Chart (e. g., getting to visit and talk the last 30 minutes of the day, a popcorn party, or the teacher reads the class a story for the last 30 minutes of the day).
6. If one rule is broken (second step of the positive hierarchy), then the class will get ten minutes of extra free time at the end of the day. If two rules are broken, then the class will receive five minutes of extra time at the next recess. If three rules are broken, then the class will get to leave two minutes early.
7. If four rules are broken (the limit posted), the class will receive no positives from the hierarchy that day.

Tough Kids Who Insist on Breaking the Rules

There will still be some students who regularly break the classroom rules irrespective of the positive or reductive consequence posted on the What If Chart. Establish a rules self-monitoring program for these students (see Monitoring Classroom Rules chart). Steps:

1. Indicate to the students that if they break three rules or more in a day, they will be taken off of the What If Chart and placed on a rules self-monitoring program.
2. Tape the self-monitoring chart to their desks.
3. On the left hand side of the self-monitoring chart, list in each square the rules that the student is having the most difficulty with (e.g., talk outs and keeping hands and feet to themselves).
4. Have the students monitor their progress each day (both in the morning and afternoon) by circling the number (1 to 4 on the chart) indicating how well they judge they are doing with the problematic rules for that part of the day.
5. Then have the teacher give the students feedback about their rating by putting one slash across the marked circle if they agree or an X if they disagree. Have the teacher give the students feedback twice per day (morning and afternoon)
6. When the student gets four of the half-day ratings with 3 or above with teacher agreement, then he or she is taken off the self-monitoring program and placed back on the What If Chart with the rest of the class.
7. A copy of the student's rules and self-monitoring chart can also be sent to the parents as a homenote.

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CLASSROOM RULES

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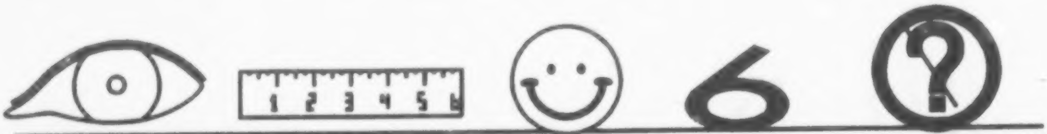

OBSERVABLE—MEASURABLE—POSITIVE—ONLY SIX—NO QUESTION

CLASSROOM RULES AS A PACKAGE

A COMPLIANCE RULE

FOLLOW YOUR TEACHER'S DIRECTIONS

DO WHAT YOUR TEACHER ASKS

A PREPARATION RULE

HAVE BOOKS, PENCILS, AND PAPER

HAVE YOUR HOMEWORK COMPLETED

A TALKING RULE

RAISE YOUR HAND AND ASK PERMISSION TO SPEAK

TALK TO YOUR FRIENDS ONLY DURING FREE TIME

AN IN CLASS BEHAVIOR RULE

KEEP HANDS AND FEET TO YOURSELF

LEAVE YOUR SEAT ONLY WITH PERMISSION

AN ON TIME RULE

BE IN YOUR SEAT BEFORE THE BELL RINGS

BE IN CLASS AND PREPARED BY 8:00 AM

A TRANSITION BEHAVIOR RULE

WALK DOWN THE HALLS WITH HANDS AND FEET TO YOURSELF

NO ROUGH HOUSING AND KEEP THE BATHROOM AND LUNCHROOM CLEAN

WHAT IF CHART?

WHAT IF YOU DO?	WHAT IF YOU DON'T?

MYSTERY MOTIVATOR

?

NUMBER

CRISIS CLAUSE

MONITORING CLASSROOM RULES

CLASSROOM RULES	MORNING	AFTERNOON
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4
	1 2 3 4	1 2 3 4

RATING SCALE-CIRCLE A NUMBER 1= NEEDS IMPROVEMENT 2= BARELY OK 3= AVERAGE 4= GREAT

IF THE TEACHER AGREES WITH THE STUDENT RATING PUT A LINE ACROSS THE CIRCLED RATING ⊘

IF THE TEACHER DOES NOT AGREE WITH THE STUDENT RATING PUT AN X ACROSS THE CIRCLED RATING ⊗

STUDENT'S NAME: DATE:

TEACHER'S NAME:

COMMENTS:

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Conduct Disorder

A Handout for Parents

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Background

Of all the disruptive behaviors occurring during childhood and adolescence, Conduct Disorder is the most prevalent. It is also one of the most serious and difficult to treat. The outcomes for children and adolescents with this disorder are frequently poor — with high rates of school drop out, gang membership, delinquency and incarceration for criminal behavior. As the conduct disordered youth approaches late adolescence and early adulthood, many will develop antisocial personality characteristics, including problems with alcohol and drugs, and significant anxiety and mood disorders.

"Conduct Disorder" describes conduct disorder is a pervasive pattern of behavior, with onset before the age of 18, in which the rights of others are violated and the rules and conventions of society are not followed. There are two subtypes — childhood onset (before age ten) and adolescent onset — and 3 levels of severity — mild, moderate and severe. The occurrence of the disorder has increased dramatically in recent years, particularly in urban settings. Conduct disorder occurs more frequently in boys than in girls. It can begin as early as 5 years of age but generally does not occur until the pre or early adolescent period.

Generally, children with Conduct Disorder are eligible for and frequently served by Special Education programs, with those students exhibiting the most disruptive and dangerous behaviors often placed in special classrooms or separate programs. Although there is some disagreement among professionals regarding the labeling of Conduct Disorder as a "disability," it does appear that these students can benefit from treatment in the school and community, particularly if diagnosed early. Without treatment, outcomes are particularly grim, with high rates of court involvement, failure to complete high school, and ongoing interpersonal and community difficulties.

Development and Characteristics

Causes: Conduct Disorder is a complex condition that cannot be traced to a single cause or factor. Most researchers and practitioners tend to agree that the disorder is most likely caused by the *interaction* of several variables such as problems in parent/child relationships, stressful environments, dysfunctional family systems, negative peer affiliations, cognitive impairment and biological influences. There is evidence that the disorder is more prevalent in children of parents with drug and alcohol problems and other psychopathological conditions such as schizophrenia and mood disorders. Research also indicates that many children with Conduct Disorder have coexisting conditions such as ADHD, depression or other developmental disorders.

Symptoms: Children diagnosed with this disorder show relatively disturbing patterns of behavior. They have little empathy for others, have limited insight into their behavior, and show little to no remorse for their actions. They exhibit behaviors that are aggressive, destructive and deceitful; they often engage in high risk activities, illegal drug and alcohol abuse, and early sexual behavior. Many have significant academic difficulties; problems in the community; a higher rate of suicidal ideation, attempts and completions; poor interpersonal relationships and self-esteem problems. In some communities, these students are at risk for gang involvement.

The behaviors associated with Conduct Disorder tend to increase in severity as children get older. Young children may be very aggressive, hyperactive and poorly socialized; they may exhibit some early learning difficulties. Often these children are first diagnosed as having an Attention Deficit Disorder (ADD) or "oppositional-defiant" disorder, or both. In middle childhood (elementary school), these children show increased aggression and hostility toward others, and often experience considerable academic difficulty. Adolescents with Conduct Disorder are likely to either drop out or otherwise disengage from academics, become involved with delinquent activities and are likely to associate with "deviant" peers (sometimes including gangs). Among younger children, parenting is often coercive and inconsistent, while among older children, there tends to be a pattern of decreasing parental supervision and involvement.

What Can Be Done?

Deviant behavior and violence are increasing at an alarming rate among individuals under the age of 18. Juvenile detention facilities are overcrowded and correctional facilities are being built in record numbers. Conduct disordered children demand immediate attention. However, Conduct Disorder is fairly resistant to treatment, particularly when symptoms appear early and the disorder is moderate or severe. Traditional therapies and interventions generally are not very successful, and no treatment in isolation is consistently effective. Most promising are multi-faceted approaches (often called "wrap-around" services), involving prevention, early identification, family intervention, school-based intervention, skills training and service coordination. For example, individual counseling, family counseling and education, along with structured, positive community programming and efficient aftercare services, would be appropriate. All too often, these youngsters are allowed to return to the same environment with the same negative influences and without supportive services. Wrap-around services must be consistent and long- term, otherwise the effects are short-lived.

Early identification and prevention: Obviously, the most effective treatment is prevention. Efforts should be made to identify high risk children and their families and to provide early treatment, aftercare and follow-up services. Because this disorder becomes increasingly difficult to treat as the child develops, it is essential to establish programs to identify Conduct Disorder at its early stages. Research indicates that programs beginning in preschool, including parent training, skills instruction, enriched academic programming and community services, can reduce the occurrence of delinquent behavior later.

Parents and teachers can play a significant part in reducing the severity of conduct problems by seeking help before problems escalate into delinquent and violent acts. Parents should be concerned and seek help when young children exhibit ongoing patterns of the following behaviors:

- **aggression** toward others (including family members, children at daycare, playmates), particularly when the aggression seems unprovoked
- **noncompliance** — refusing to obey adult requests, refusing to follow routines at home or daycare or at school, ignoring requests, tantrumming when asked to do (or stop doing) something
- **limited or inappropriate social skills** — has difficulty playing and sharing with other children, tries to control others, disrupts the play of others, takes materials away from others, laughs or cries when it isn't appropriate, threatens others, sexualized behavior, etc.
- **early "delinquent" behavior** — stealing, damaging property

If these behaviors persist, parents should contact their school district or health care provider for information about assessment and possible treatment options. In the school setting, staff should consult with parents about their concerns and refer such students to their support services personnel or special education team for screening and consultation.

Family-based intervention: Programs that combine behavior management training, stress management and parent involvement in the school are related to more positive outcomes for children with early symptoms of Conduct Disorder. At home and at school, expectations need to be clear, limits set and consequences (i.e., loss of privileges, time outs) immediate and consistent. Prosocial behavior also should be rewarded and reinforced consistently. There are a number of excellent parent education and management training programs available to families, often through community agencies and health care providers; school districts might also offer classes in child management through continuing education and community education programs. Books and videos are also available. When problems persist and become severe, however, it is important that parents seek professional support and not rely on "self-help".

School-based intervention: At school, children can receive support through a variety of programs aimed at the class or school as a whole and/or programs specially designed for the individual child. School psychologists and behavioral specialists can assist other school personnel to design and set up appropriate interventions for children with conduct problems. It is important that the school and classroom environment is positive with firm and consistent expectations for behavior. Communication between home and school is very important; frequent contact between parent and teacher regarding the child's behavior progress and what does and does not work will help establish a consistent set of expectations.

Because co-existing problems such as attention deficits and underachievement are often found among students with Conduct Disorder, it is essential that the child's school program addresses any needs in these or other areas related to school performance. Assuring appropriate curriculum and instruction can lead to significant change not only in academic performance but in the behavior of these students, as co-existing conditions can contribute to and/or exacerbate Conduct Disorder. If parents feel that their child has some problems with school work, completing tasks or paying attention, they can request a conference to discuss these concerns and seek evaluation to assure that their child receives appropriate instruction.

Skills training: Children with Conduct Disorder often have problems learning skills such as social problem solving, anger management and self control. Training in these specific skills is often necessary in order to provide the Conduct Disorder student with acceptable alternative behaviors in interpersonal situations. The most effective approaches to social skills training and anger management training are programs that combine specific skills instruction with more general behavioral intervention strategies. Programs to train specific social and anger management skills may be available at school or through community agencies and healthcare providers. Whatever program is used, parents should be aware of the goals of the program and ways that they can help their children practice new skills at home.

Service coordination: With many components of the child's life involved in intervention, it is essential that service providers work together rather than duplicate or negate each other. This can be difficult in situations where each agency (the schools, courts, welfare and healthcare) has its own eligibility rules, terminology and funding restrictions. Communication is key to effective service delivery. Parents should seek the services of a "case manager," someone who takes charge of communication and assuring coordination of services. A case manager might be a school social worker, a county or welfare worker or a case worker from the health provider.

Resources

Clark, L. (1996). ***SOS Help for parents (2nd edition).*** **Parents Press.**

Illustrated guide to managing difficult child behaviors with practical suggestions, including time out, use of rewards, natural consequences, etc. Use as a self-help guide or as part of a parent training class.

Dinkmeyer, D. & McKay, G. (1990). ***Parenting Teenagers: Systematic Training for Effective Parenting (STEP),*** **Revised Edition. American Guidance Service.**

This is a self-help book for parents of middle and high school students, designed to be used alone or as the text for parent training groups. The book is a 10-week self-study program with specific homework aids and a chart of chapter highlights. The use of reward and punishment to change teen behavior is discouraged while the use of logical consequences is recommended.

Jenson, W. R., Rhode, G., Reavis, H. K., & Neville, M. (1994). ***Why me? Practical parenting techniques for tough childhood problems.*** **Longmont, CO: Sopris West.**

Recommended for parents and for professionals conducting parent training classes. Addresses problems often associated with the development of delinquent behavior.

Martin, M. & Waltman-Greenwood, C. (Eds.). (1995). ***Solve your child's school-related problems.*** **HarperPerenniel.**

Practical suggestions and information about a wide range of child problems. In particular see the chapter on Anger Control and suggested motivators in the Appendix.

Severe, S. (1996). ***How to behave so your children will, too!*** **Greentree Publishing.**

Stories and practical ideas for consistent behavior management, controlling anger, avoiding power struggles.

Some of the material for this handout is adapted from a chapter on Conduct Disorders by Russell Skiba, in Children's Needs II *(G. Bear, K. Minke & A. Thomas, Eds.), published by the National Association of School Psychologists (1997).*

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Conduct Disorder

A Handout for Teachers

by John J. DeFrancesco, Ph.D.
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Background

Of all the disruptive behaviors occurring during childhood and adolescence, Conduct Disorder is the most frequently assessed and diagnosed. It is also one of the most serious and difficult to treat. The prognosis for children and adolescents with this disorder generally ranges from guarded to poor. As the conduct disordered youth approaches late adolescence and early adulthood, many will develop antisocial personality characteristics, alcohol and drug-related problems and addictions, and significant anxiety and mood disorders. The *Diagnostic and Statistical Manual* (DSM-IV) describes Conduct Disorder as a pervasive pattern of behavior, with onset before the age of 18, in which the rights of others are violated and the rules and conventions of society are not followed. The Manual describes two subtypes — childhood onset (before age ten) and adolescent onset — and 3 levels of severity — mild, moderate and severe.

Children diagnosed with this disorder show relatively disturbing patterns of behavior. They have little empathy for others, have limited insight into their behavior, and show little to no remorse for their actions. They exhibit behaviors that are aggressive, destructive and deceitful; they often engage in high risk activities, illegal drug and alcohol abuse, and early sexual behavior. Many have significant academic difficulties; problems in the community; a higher rate of suicidal ideation, attempts and completions; poor interpersonal relationships and self-esteem problems. The prevalence of the discrder has increased dramatically, particularly in urban settings. Conduct disorder occurs more frequently in males than in females. It can begin as early as 5 years of age but generally does not occur until the pre or early adolescent period.

Generally, children with Conduct Disorder are eligible for and frequently served by Special Education programs, with those students exhibiting the most disruptive and dangerous behaviors often placed in segregated classrooms. Although there is some disagreement among professionals regarding the labeling of Conduct Disorder as a "disability," there is little research to support excluding these students from special education services and considerable data indicating more negative outcomes (dropping out, delinquency) when youth with Conduct Disorder are not treated.

Development

The literature is burgeoning with research regarding the etiology of Conduct Disorder. It is, however, a complex condition that cannot be traced to a single cause or factor. Most researchers and practitioners tend to agree that the disorder can be caused by the interaction of several variables such as poor parent/child relationships, negative environments, dysfunctional family systems, physical abuse, neglect, negative peer affiliations, cognitive impairment and biological influences. There is evidence that the disorder is more prevalent in children of parents with drug and alcohol problems and other psychopathological conditions such as schizophrenia and mood disorders. Research also indicates that many children with Conduct Disorder have coexisting conditions such as ADHD, depression or other developmental disorders.

The behaviors associated with conduct disorder tend to increase in severity as children get older. Young children may be very aggressive, hyperactive and poorly socialized; they may exhibit some early learning difficulties. Often these children are first diagnosed as having an attention deficit disorder (ADD) or "oppositional-defiant" disorder, or both. In middle childhood (elementary school), these children show increased aggression and hostility toward others, and often experience considerable academic difficulty. Adolescents with Conduct Disorder are likely to either drop out or otherwise disengage from academics, become involved with delinquent activities and are likely to associate with "deviant" peers. Among younger children, parenting is often coercive and inconsistent, while among older children, there tends to be a pattern of decreasing parental supervision and involvement.

What Can Be Done?

Non-normative behaviors and violence are increasing at an alarming rate. The majority of these crimes are being committed by children under the age of 18. Juvenile detention facilities are overcrowded and correctional facilities are being built in record numbers. Conduct disordered children demand immediate attention. However, Conduct Disorder is fairly resistant to treatment, particularly when there is an early onset and the disorder is moderate or severe. Traditional therapies and interventions are generally not very successful, and no treatment in isolation is consistently effective. Most promising are multi-faceted approaches (often called "wrap-around" services), involving prevention, early identification, family intervention, school-based intervention, skills training, and service coordination. For example, individual counseling, family counseling and education, along with structured, positive community programming and efficient aftercare services, would be appropriate. All too often, these youngsters are allowed to return to the same environment with the same negative influences and without supportive services. Wrap-around services must be consistent and long- term, otherwise the effects are short-lived.

Early identification and prevention: Obviously, the most effective treatment is prevention. Efforts should be made to identify high risk children and their families and to provide early treatment, aftercare and follow-up services. Because this disorder becomes increasingly difficult to treat as the child develops, it is essential to establish programs to identify Conduct Disorder at its early stages. Research indicates that programs beginning in preschool, including parent training, skills instruction, enriched academic programming and community services can reduce the occurrence of delinquent behavior later.

Parents and teachers can play a significant part in reducing the severity of conduct problems by seeking help before problems escalate into delinquent and violent acts. When young children exhibit ongoing patterns of aggression, noncompliance and limited or inappropriate social skills, parents should contact their school district or health care provider for information about assessment and possible treatment options. In the school setting, staff should consult with parents about concerns and refer such students to their support services personnel or special education team for screening and consultation.

Family-based intervention: Programs that combine behavior management training, stress management and parent involvement in the school are related to more positive outcomes for children with early symptoms of Conduct Disorder. At home and at school, expectations need to be clear, limits set and consequences (i.e., loss of privileges, time outs) immediate and consistent. Prosocial behavior also should be rewarded and reinforced consistently.

School-based intervention: Among the most effective interventions are those providing schoolwide behavior management systems as well as individually designed interventions for targeted students with difficult behaviors. The classroom environment should be positive and reinforce prosocial behavior, while negative, coercive environments (at home and at school) are ineffective. The emerging technology of functional analysis (use of interview and observation to determine the purpose of a behavior and the factors maintaining it) offers procedures for better understanding conduct and behavior problems — school psychologists and behavioral specialists can assist other school personnel obtaining data and designing appropriate interventions.

Because co-existing problems such as attention deficits and underachievement are often found among students with conduct disorder, it is essential that school personnel implement strategies to address these issues. Assuring appropriate curriculum and instruction can lead to significant change not only in academic performance but in the behavior of these students, as co-existing conditions can contribute to and/or exacerbate Conduct Disorder.

Skills training: Children with Conduct Disorder often have deficits in alternative skills such as social problem solving, anger management and self control. Training in these specific skills is often necessary in order to provide the Conduct Disorder student with prosocial options in interpersonal situations. The most effective approaches to social skills training and anger management training are programs that combine specific skills instruction with more general behavioral intervention strategies.

Service coordination: With many components of the child's life involved in intervention, it is essential that service providers work together rather than duplicate or negate each other. Wrap-around services should involve collaboration across agencies (school, health care, courts, welfare), case management, flexible funding and unconditional care. This can be difficult in situations where each agencies has its own eligibility rules, terminology and funding restrictions. Communication is key to effective service delivery.

Resources

Alberto, P.A. & Troutman, A.C. (1995). *Applied behavior analysis for teachers* (4th edition). Englewood Cliffs, NJ: Merrill.

Borduin, C. M., & Henggeler, S. W., & Manley, C. M. (1995). Conduct and oppositional disorders. In V. Van Hasselt and M. Hersen (Eds.), *Handbook of adolescent psychopathology*. New York: Lexington Books.

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Kazdin, A. E. (1987). *Conduct disorders in childhood and adolescence*. Beverly Hills, CA: Sage.

Maxmen, J. S., & Ward, N. (1995). *Essential psychopathology and its treatment*. New York: Norton.

Peters, R.D., McMahon, R.J., & Quinsey, V.L. (Eds.) (1992). *Aggression and violence throughout the lifespan*. Newberry Park, CA: Sage.

Rhode, G., Jenson, W. R., & Reavis , H. K. (1993). *Tough kid book: Practical classroom management strategies*. Longmont, CO: Sopris West.

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Some of the material in this handout is adapted from Russell Skiba's chapter, Conduct Disorders, published in Children's Needs II *(see resources above).*

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Conflict Resolution and Peer Mediation

A Guide for Educators

by Mary M. Chittooran, Ph.D.
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Background

Conflict is both natural and inevitable in human relations. It is neither good nor bad in itself, but it is the response to conflict that makes it either a destructive experience or the medium through which problems can be aired and solutions reached. Two common responses to conflict — avoidance/withdrawal and verbal or physical confrontation — are not constructive and usually worsen matters. Another response is communication, which is the most effective way to resolve differences between individuals.

Schools should teach students conflict resolution skills since unresolved conflicts can lead to poor academic performance, low self-esteem and other social-behavioral problems. Typical school-based programs focus on teaching a conflict resolution curricula, skills-based mediation programs, or a combination of the two.

Peer Mediation

One of the most frequently used skills-based approaches to conflict resolution is that of peer mediation. Used to solve serious conflicts that cannot be handled independently by the individuals involved, peer mediation relies on an impartial third party to help students engaged in a conflict to use communication, negotiation and problem-solving skills to reach a mutually beneficial agreement. The mediator does not render a judgement, force a solution, or otherwise influence a decision.

Rationale: Peer mediation is designed to teach students to find alternative ways to resolve conflicts and to encourage them to solve their own problems in a constructive fashion. When peer mediation is effective, it allows students to understand and respect different points of view. Peer mediation teaches problem-solving and decision-making, improves communication and critical thinking skills, increases cooperation and reduces adult intervention in student conflicts. Positive effects have been found in elementary, middle and high schools and with children of varied backgrounds and ability levels.

The Peer Mediator: The peer mediator is usually nominated by peers or teachers and is then selected on the basis of teacher recommendations. The most effective peer mediators have good judgment, enjoy the respect and trust of their peers, display leadership abilities and have good communication skills. They are not necessarily the best-behaved students in their classes, or "straight -A" students. The peer mediator's role is to monitor the problem-solving process, to be unbiased, to listen empathetically to the disputants, to be respectful to them, to help them work together to solve problems and to keep information confidential. Peer mediators undergo specific training in conflict resolution and mediation, with most sources recommending between 12 and 20 contact-hours, depending on the age of the student.

Peer Mediation Procedures

Students may request mediation when they are involved in a dispute or they may be referred by teachers, administrators and parents. In any event, participation is voluntary. Once students agree to engage in mediation, the peer mediator assigned to a case arranges a meeting at some neutral setting. Students are asked to sit facing each other, with the peer mediator between them. Other parties are usually not permitted in the room. The following are the six typical steps used in mediation:

1. Open the Session

Students are introduced to each other and to the peer mediator. Ground rules are stated and discussed. Both disputants must agree to respect each other, to be honest, to stay calm, to listen to the other's point of view, to be willing to cooperate to find a solution and to focus on issues, not the person (no name-calling, blaming, shouting, or interrupting). The peer mediator secures a commitment from both parties to follow all ground rules.

2. Gather Information

Each student is asked, one at a time, for their version of the problem. Mediators may assign each student a specific amount of time during which they may speak uninterrupted. The peer mediator's role is to use effective verbal and nonverbal communication skills such as eye contact, empathy, restating, summarizing and clarifying to obtain as much relevant information as possible.

3. Focus on Common Interests

The peer mediator then asks questions to determine what each student wants and why they want it. Common interests are identified and stated and form a springboard for further discussion. For example, the students may indicate that they have a common interest in solving the problem as quickly as possible.

4. Create Options

The peer mediator then explains that brainstorming will be used to find solutions to the conflict and describes the rules for brainstorming. Participants try to come up with as many solutions to the problem as possible. However, at this stage, ideas may not be judged, evaluated or criticized, however far-fetched or unworkable they may seem. The peer mediator may write down ideas as they are offered and may ask questions for clarification.

5. Evaluate Options and Choose a Solution

The students then evaluate their list of options with the help of the peer mediator. Their task is then to decide on one option that best meets their needs. The peer mediator then summarizes the solution.

6. Generate an Agreement and Seal It

Each student says what they will do to solve the problem. The agreement is written down by the peer mediator. The students sign the document and the peer mediator signs as a witness. The mediator congratulates the students on a successful session and encourages them to shake hands to seal the deal. Students may seek additional mediation if the agreement is not working. Changes in the original agreement must be agreed upon and signed by both students and the peer mediator.

Critical Components

Peer mediation can be a highly successful tool for conflict resolution in the schools. When starting a program, the critical components are:

1. clear, specific goals and procedures
2. an advisory committee of school professionals, parents and community representatives
3. adequate funding and resources
4. community support
5. handbooks and brochures advertising the new program
6. selection and training of program coordinators and peer mediators
7. orientation sessions for staff and students
8. established evaluation criteria
9. careful monitoring procedures

Resources

Organizations

CHAMPS Peer Leadership, Inc., 14425 N. Scottsdale Rd., Suite 400, Scottsdale, AZ 85254-3449, (602) 991- 9110.

Community Board Program, Inc., 1540 Market Street, Suite 490, San Francisco, CA 94102, (415) 552-1250.

National Institute for Dispute Resolution, National Association for Mediation in Education, 1726 M Street, NW., Suite 500, Washington, DC 20036-4502, (202) 466-4764.

Peace Education Foundation, 1900 Biscayne Boulevard, Miami, FL, 33132-1025, 1-800-749-8838.

Resolving Conflict Creatively Program (RCCP). National Center, 163 Third Avenue, P.O. Box 103, New York, NY 10003, (212) 387-0225.

Materials, Programs and Curricula

Crawford, D., & Schrumpf, F. (1994). *Creating the peacable school: A comprehensive program for teaching conflict resolution.* Research Press, Inc. Champaign, Il; (217) 323-3273. For grades 3-12.

Johnson, D. & Johnson, R. (1991). *Teaching students to be peacemakers.* Edina, MN: Interaction Book Company, 7208 Cornelia Drive, Edina, MN 44535; (612) 831-9500.

Kreidler, W. (1984). *Creative conflict resolution: More than 200 activities for keeping peace in the classroom, K-6.* Glenview, Il: Scott Foresman.

McGarr, M., Rain, B., & Walker, J. (1993). *RAPP (Resolving All Problems Peacefully).* Ferguson Middle School, Ferguson-Florissant School District, 701 January Avenue, Ferguson, MS 63135.

Safe Schools Resource Guide (1994). North Carolina State Department of Public Instruction, Raleigh. Instructional Services (EDRS Document No. ED 381 718).

Schrumpf, F., Crawford, D., & Usadel, H. C. (1996). *Peer mediation: Conflict resolution in schools, revised edition.* Box 9177, Champaign, IL 61826; (217) 352-3273. Program guide and accompanying video, useful through high school.

Selected References

Benson, A., & Benson, J. M. (1993). Peer mediation: Conflict resolution in schools. *Journal of School Psychology, 31*, 427-430.

Crawford, D. & Bodine, R. (1996). *Conflict resolution education: A guide to implementing programs in schools, youth-serving organizations, and community and juvenile justice settings.* Program Report, Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. Washington, D.C.

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Defusing Disruptions

A Crisis Intervention Method

**by Nina Shandler, Ed.D.
Amherst, MA**

Introduction: "David"

Demanding, defiant, disruptive — David was typical of students who appear on my case load. As a School Psychologist in a non-traditional role, I provide therapeutic services for psychologically at-risk children. In our elementary school of over 600 students with a diverse racial, ethnic and socio-economic mix, the most needy students are often the most volatile. David's temper erupted regularly. By the time referral for psychological support services had been made, the necessary meetings held and the papers signed, I had observed David repeatedly.

David responded as though he were constantly under siege. He perceived teacher corrections and directions as threats, as ordeals designed to hurt him. Always vigilant, always suspicious, sometimes the pressure overwhelmed him. Often, seemingly unpredictably, David would explode. Agitated beyond his ability to control himself, he would scream obscenities at his teacher, throw his books across the room, or run out of class turning over chairs. When the school disciplinarian was called to the scene of these crises, the level of David's mutinous behavior would increase. He would do everything within his power to escape being controlled or subdued. He would run away, hide, spit, curse, kick, punch. Finally, he would be caught, restrained, and banished to a time-out room. Isolated, he would tantrum until tired, then sleep.

Every time this scenario played itself out, David learned the lessens of delinquency. He learned to distrust adults. He learned he didn't belong with good students. He learned he was a trouble-maker. He learned that bigger and stronger people win. David did not learn the lessons of success. He did not learn to respect adults. He did not learn to calm and control himself. He did not learn to appreciate his strengths. He did not learn to cooperate with classmates. He did not learn to take responsibility. Each explosive episode destroyed still more of the already fragile personal resources he needed to become a confident, competent, contributing member of our school community.

As with many students before and since, I determined that my staff and I would respond to David's outbursts differently. We would refuse to intimidate, or confront, or lecture, or argue, or humiliate, or corner or chase. Instead, we would defuse his emotions and teach him responsibility using an eight-step process:

STEP 1: Offer a Safe Place and a Calming Activity

STEP 2: Reflect Feelings

STEP 3: Look for Positives

STEP 4: Appreciate the Positives

STEP 5: Redefine Identity

STEP 6: Explore Options

STEP 7: Plan the Future

STEP 8: Teach Responsibility and Repair Relationships

STEP 1: Offer a Safe Place and a Calming Activity

When out-of-control students threaten the learning environment and the safety of others, the first priority is to protect students and staff. Getting disruptive students to leave classrooms quickly without argument or force takes on primary importance.

Even with students who have a history of assaultive behavior, we have accomplished this primary goal by offering them a safe place and a calming activity. We are sure to approach them in a non-threatening manner. We come close enough to speak to them quietly, then stop. We confidentially invite them to come with us to play with clay or draw a picture or take a walk. After inviting students, we walk toward the door and motion for the student to follow. If necessary, we repeat the invitation once or twice. Nearly all students follow.

STEP 2: Reflect Feelings

As we walk with distressed students, we immediately reflect their feelings. We observe their body language and paraphrase their complaints. We resist any temptation to reason or reprimand. We simply reflect. "You're really mad." "You're so angry, you feel like you never want to go back to class." "You feel like your teacher isn't fair." "You feel like you hate everyone in your class." Surprised by the lack of confrontation and correction, most students spontaneously respond, "That's right, you got it."

STEP 3: Look for Positives

Feeling listened to has a magically calming effect. Within moments students are able to reason. Without guidance, they will reason negatively; they will blame others and justify themselves. Before they begin to think, we ask, "What did you do right?" This question startles them. Often they object to the question and take unexpected responsibility for their actions. "What did I do right! I didn't do anything right! I kicked a table, threw a chair and swore at my teacher." We avoid any temptation to agree. We ignore their response and stick to our agenda. "You did do something right. What did you do right?" If they are unable to think of a positive action, we supply one. We can always say, "You came with me. Even though it was hard for you to come, you came. That was good." Over time we can supply other positive behaviors — we take note of any work accomplished, any successful time on the playground, any appropriate class participation. As soon as the student's attention is focused on a positive behavior, we move on to step four.

STEP 4: Appreciate the Positives

Now, we applaud their positive behavior. As we get out clay or hand them drawing materials or walk around the playground, we continue, "I'm proud of you for that. Why do you think I'm proud of you?" If student give us an answer, we agree with them. If students are unable to answer, we tell them why we are proud of them. "I'm proud because you did a hard thing. I know its hard for you to leave class when you're upset, but you came with me." "I'm proud because you finished your homework." "I'm proud because you're trying hard and doing better."

Our guiding principle is that success breeds success. We identify small achievements that build a foundation for positive change.

STEP 5: Redefine Identity

Most children who consistently find themselves in trouble believe they are trouble-makers. We use the positive behaviors we have identified to undermine that identity. We ask, "What can you do?" We look for a statement of competence that refutes the negative self-perception. "I can control myself." "I can do what I'm asked to do." "I can do hard work." "I can be a good friend." If students have difficulty coming up with their own self-affirming statement, we come up with one. Then, we tease them into repeating it five times along with us.

STEP 6: Explore Options

After students have been calmed and affirmed, we bring up the disruptive incident. We ask them, "What upset you?" We look for a simple straight-forward explanation. "The work was too hard." "The teacher wasn't fair." "He was mean." We follow their explanation with another question, "What can you do better if that happens again?" We help them think of positive possibilities: try harder, take a deep breath, ask for help, tell yourself to stay calm, say how you feel, walk away.

STEP 7: Plan the Future

Once we have considered a few positive alternatives, we ask, "What will you do next time?" We ask for a simple commitment. Often, we write down that one-sentence commitment and have students sign it.

STEP 8: Teach Responsibility and Repair Relationships

Teachers and administrators usually make the mistake of confronting distressed students with their responsibility before these students are able to face their accountability. Students in an agitated state devote all their resources to self-defense. In the initial stage of a disruptive incident, confrontation will make matters worse not better. However, at this later stage, students can and must take responsibility for their behavior.

In holding students responsible, we teach them to understand that their behavior has damaged relationships and that these relationships need to be repaired. Teachers and other students feel hurt, anger, distrust, fear and resentment following disruptive episodes. The students at the center of these cyclones need to understand that if they do nothing to take responsibility, their reputations will degenerate and their alienation will grow.

To encourage students to take responsibility and repair relationships, we ask, "What can you do to make your teachers and other students feel better?" We have found that notes of apology go far to mend relationships and restore status. Notes are most effective if students give up recess to write them and if they include their plans to do better in the future.

In addition to reparation work, students need to be held accountable for any work missed while talking with us. Some particularly needy students gain secondary gratification from their meetings with us and seek our company. If they know that any time spent processing their outbursts will be made up working during recess, lunch or after school, they do not act out to gain our support.

Optimistic Outcomes

David responded typically to our non-confrontational approach. Suspicious of our invitation to "play", he came anyway . Surprised by being listened to, he calmed down. Shocked by the question "What did you do right?", he did not blame or justify. Appreciated for his positive gains, he began to think of himself differently. Supported by our time together, he began to take responsibility and repair relationships. Perhaps most importantly, our reaction to his outbursts taught him to trust adults to help. He began seeking us out when he was overwhelmed or on-the-edge. Our responses to his disruptive behavior became the foundation for supportive counseling relationships, rather than the source of continued power struggles. With David, as with most multiple-risk children, the road to success was not paved with a single intervention or a short-term solution. But, this method dramatically diminished the harm done by prolonged and repeated public displays of disruptive behavior.

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Delinquency

A Handout for Parents and Teachers

by Judy Johnson
University of Northern Colorado

Background

Generally, the term delinquency refers to any illegal act committed by a juvenile (someone below the legal age of adulthood, which varies from state to state). A youth can be considered delinquent for breaking any federal, state, or local criminal laws. In addition, they can considered delinquent for committing status offenses, which are behaviors that are not considered crimes for adults (truancy, running away, drinking alcohol, etc.). Juvenile delinquency impacts us all through costs of the juvenile justice system, rehabilitation and property damages, as well as the human suffering of crime victims.

The contribution of youth to the crime problem varies depending on the crime. In 1994, juveniles were responsible for:

- 10% of murders
- 14% of forcible rapes
- 20% of robberies
- 21% of burglaries
- 25% of larceny-thefts
- 48% of arsons

There was a 50% increase from 1988 to 1994 in the number of juveniles arrested for violent crime. Although juvenile crime has been traditionally considered a male problem, there was an increase in the percentage of females arrested in most offense categories. Since these are only the juveniles that have been arrested, the juvenile crime rate is higher than these figures, but to what degree is uncertain.

Development and Causes

There are a variety of theories regarding the development of delinquent behaviors. However, it is a complex social behavior that usually cannot be attributed to any one causal factor. There is no compelling evidence that race, social or economic factors are strongly related to delinquency.

Loeber (1990) identified three paths leading to delinquent and antisocial behavior. The first path, an "aggressive versatile path," begins in the preschool years and involves, in addition to hyperactivity, a variety of aggressive and nonaggressive conduct problems. The next path is a "nonaggressive path" which begins in late childhood or early adolescence and usually involves nonaggressive conduct problems (theft, truancy, substance abuse, lying) that are often committed with peers. The final path is an "exclusive substance abuse path" that begins in early to middle adolescence and with little history of other conduct problems.

One of the strongest predictors of delinquency and antisocial behavior during adolescence is aggression; it signals criminal behavior in adulthood. In addition, a number of studies have found a relationship between family variables and delinquency. These include low levels of warmth and supportiveness, as well as high rates of marital and family discord. Some research has shown that families of female delinquents may be even more dysfunctional than those of male delinquents. Other factors include ineffective and lax parental discipline and parents' involvement in criminal activities.

Peer involvement is also related to delinquent activity. A high percentage of delinquent behavior is carried out with peers and such behavior provides continued support and acceptance.

What Can I Do as a Parent?

In treating delinquency, individual and family counseling should be considered. Prevention of delinquent behaviors in youth is the most effective role for parents and teachers. Keep in mind the following:

- A nurturing and supportive relationship, as well as a balanced and consistent system of discipline, is beneficial for your child.
- Parental support groups are often available to help you deal with the difficult behaviors of your child and to learn additional parenting strategies.
- Identify and address any negative family patterns (alcoholism, grief, domestic violence, abuse) through professional counseling.
- Communicate with teachers and school staff to see if your child is attending school and how he/ she is doing academically.

What Can I Do as a Teacher?

- Teach appropriate social, problem-solving and coping skills. Peer groups focused in this area have been shown to be effective.
- Give recognition for positive behavior, activities and accomplishments.
- Keep open communication with the family and other agencies the child is involved in (i.e. probation, mental health).
- Encourage involvement with positive adult role models (such as Partners or a Big Brother program).
- Work to insure that the student experiences success both educationally and, when possible, vocationally. Provide as many experiences as possible for the student to bond to the school and positive peers.

Reference

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Resources

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Jenson, W. R., Rhode, G., Reavis, H. K., & Neville, M. (1994). *Why me? Practical parenting techniques for tough childhood problems.* Longmont, CO: Sopris West.

McCarney, S. B., Wunderlich, K. C., Bauer, A. M. (1993). *The pre-referral intervention manual.* Columbia, MO: Hawthorne Educational Services.

Rhode, G., Jenson, W. R., & Reavis, H. K. (1993). *The tough kid book.* Longmont, CO: Sopris West.

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NATIONAL
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PSYCHOLOGISTS

Firesetting

A Handout for Teachers and Parents

by Judy Johnson
University of Northern Colorado

Background

Youth were responsible for 48% of recorded intentional fires in 1994. Playing with fire is the leading cause of death for preschoolers and second main cause of accidental death for 5- to 14-year-olds in the United States. Although curiosity about fire occurs as a normal part of development, the consequences of fire-play can be tragic. A dangerous combination occurs when a child has limited supervision and access to matches and lighters.

Although any instance of firesetting is of concern, the firesetter could be engaging in anything from curious fire-play to arson. Four types of firesetters have been identified : (a) young children (under age 10) who start fires accidentally; (b) delinquent firesetters acting out against society; (c) older children who have other problems and set fires as a cry for help (the largest group); and (d) severely emotionally disturbed firesetters (the least prevalent type of firesetter).

Development and Causes

Fascination with and attraction to fire is a typical phenomenon in the development of young children. Curiosity about fire is most common in 2- to 7-year-olds. Interest in fire usually diminishes around the age of 9 or 10. At this age a child is no longer considered a curiosity firesetter and the possible existence of other problems must be investigated. However, there have been cases of pathological firesetters at earlier ages.

Like many other behavior problems, firesetting occurs more frequently among boys. Young children who set fires tend to do so in or near their own homes. Older children are more likely to set fires in a social context, away from the home environment. A social learning theory of the development of pathological firesetting has been proposed. In some cases, natural curiosity may be reinforced by social factors such as negative attention and the sensation of power surrounding the child's first experience with fire. The child may then develop the symptom of firesetting as a pathological coping mechanism.

Although all instances of firesetting or suggestions of future plans to set fires should be considered serious, assessing the level of seriousness of a child's involvement in a fire-related incident is a very difficult task. Some of the issues that should be addressed include the following:

- The age of the child. Is the behavior typical for a child of a given age?
- Frequency and duration. Has the behavior occurred before? How often? In what setting? Does the child plan to do it again?
- Are there any other behavior problems? Is the firesetting a sign of other family, school or interpersonal problems?
- What circumstances preceded the behavior? What motivates the child to set fires?
- What were the ramifications of the firesetting (burn marks on the carpet or major damage to the family home)?

What Can I Do as a Parent?

- Keep matches and lighters away from your child. Many 3-5-year-old children will experiment with fire if given the chance. Have smoke detectors in your home and a fire escape plan.
- Teach children how to use fire safely. Under adult supervision, they can light the birthday candles, the campfire or the fireplace. Emphasize that matches and lighters are not toys.
- Teach your child to stop, drop and roll when his/her clothing is on fire.
- Watch for any signs of experimenting with fire (matches in clothing, burns or smoky odor).
- Teach your children how to deal with peer pressure. Over 50% of fires involving juvenile firesetting are set with friends.
- Seek help from the fire department or the local mental health center if the firesetting continues. Professional help may be needed.

What Can I Do as a Teacher?

- Establish and implement a fire safety unit in your curriculum or at your school.
- Familiarize yourself with the agencies that offer services for juvenile firesetters. This may include fire departments, mental health professionals, probation departments or school districts.
- Act quickly in responding to any firesetting behavior and make referrals to appropriate agencies.
- Learn about the characteristics of juvenile firesetters and watch for any signs of experimentation with fire.

Resources

Federal Emergency and Management Agency, U.S. Fire Administration (1988). *Preadolescent and adolescent firesetter handbook.* Washington, DC: Author.

Firesetter Handbooks (1988). Very informative handbooks on the characteristics of firesetters, assessment and intervention. Cost: Free. Source: U.S. Fire Administration, 16825 South Seton Avenue, Emmitsburg, MD 21727.

Curious Kids Set Fires, a school-based fireplay prevention curriculum. Cost: Free; Source: U.S. Fire Administration, 16825 South Seton Avenue, Emmitsburg, MD 21727.

National Firehawk Foundation, P.O. Box 27488, San Francisco, CA 94127. A program that has local chapters that pair firefighters with firesetters in an educational and therapeutic relationship.

Safer Kids! Community Action Guide for Children's Fire Safety Education Program; includes lesson plans, games, video tape sponsored by the BIC corporation.Cost: Free; Source: Paul Schwartzman, Ph.D., 20 N. Main Street, Pittsford, NY 14534.

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Lying

A Handout for Parents and Teachers

by Yvonne Godber
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Background

Honesty is a trait required in positive social relationships. Individuals who repeatedly lie risk suffering social exclusion and developing a negative self concept. Throughout our lives we are continuously confronted with decisions about whether or not we should tell the truth, and whether those around us are being honest. Clearly, there are differences in the types, magnitude, incidence and consequences of lies. A lie's seriousness depends on the intent of the speaker and the effect it has on others.

Some lies can actually be considered pro-social. For example, telling a "white lie" to make someone else feel good about themselves, embellishing a funny story, or excluding information in order to protect someone from harm can be appreciated. These types of lies are very common, are socially accepted and do not typically require any intervention.

However, excessively "twisting the truth" can interfere with the individual's social relationships and should be addressed. Patterns of lying requiring immediate attention are those lacking any pro-social motive. These lies are told in malice to trick someone else; to avoid a negative consequence; and/or to gain an undeserved reward.

Lying has been linked to adjustment difficulties later in life. Lies erode trust, an important component of socialization. People do not tend to maintain positive relationships with someone whom they do not trust. Repeated dishonesty negatively impacts friendships by limiting opportunities for positive social interactions. Thus, when it feels like a child has turned into Pinocchio, the problem must be addressed. The type of intervention depends on the age of the child and the reasons for the dishonesty. However, the goal of any intervention addressing lying remains the same: To help an individual tell the truth and realize why it is important to be honest.

Development

As children develop, their concepts and moral evaluations of truthfulness and lying change. The rationalization for not lying moves from a fear of an external reprimand to an understanding that lying dissolves trust in relationships. This realization continues to develop through life as people base decisions on their own, personal moral code of ethics, regardless of whether or not the decision is supported by others. Although the reasons for telling the truth may change throughout childhood and adolescence, even very young children are able to distinguish between the concepts of lying and truthfulness. Research suggests that young children also know that it is not "O.K." to lie, and are able to judge the severity of lies based on the intent of the speaker. However, as we are well aware, just knowing what is right and wrong does not necessarily guarantee that children will choose the more appropriate, socially-accepted behavior.

It is important to note that excessive lying does not usually appear in the absence of other behavior problems. In fact, research has shown that lying is related to difficult parent-child and peer-child relationships, conduct disorder, a social skills deficit, wishful thinking, and/or impulse control problems. Assessment and intervention efforts need to focus on the overall behavior and social patterns, rather than solely working in isolation on the problem of lying. The child's behavior patterns as a whole should direct the focus of the intervention. Examples of different intervention strategies, all of which focus on encouraging truthfulness, include parent training, behavioral contracting, self-control training and social skills training.

A child may quickly realize that misbehavior is an efficient way to get one's own way — for example through lying, cheating, and/or stealing. The element of chance can reinforce both positive and negative behaviors. While often difficult to prove that someone has told a lie, the punishment for lying is frequently inconsistent and the immediate rewards for lying remain high. If the trend is permitted to continue, the child is at risk for a powerful habit potentially leading to other antisocial behaviors and difficulties with relationships. In lying, as with any activity, the more opportunities a child has to practice and be rewarded for the behavior, the more skilled he/she will become at it. In turn, it becomes increasingly difficult to catch the lies. Adolescents who have had the chance to develop into "masters of deception" tend to put themselves at greater risk for potentially harmful activities. Again, it is important to intervene early to halt the cycle of negative behaviors of which lying is only a part.

What Can I Do as a Parent?

The following recommendations can be helpful when dealing with the child who lies. If intentional lying persists despite your efforts, be sure to contact your school psychologist or community mental health agency for advice or evaluation, as lying might be a symptom of a more serious problem.

- Be a good role model — show your child in your actions and in discussions with your child that you value honesty. Avoid telling even "little white lies" which can send your child mixed messages. Remember, your actions speak louder than words.
- Stay calm when your child has lied. Deal with the situation and do not deny that your child has been untruthful. Let the child know how you are aware of the dishonesty and inform him/her of the consequence. Do not argue with the child. Calmly say that he/she knows what to do and that further arguing will result in an additional consequence. Be sure to follow through on your consequences as stated.
- When your child misbehaves and lies about his/her involvement, explain to the child that an extra punishment is earned for the dishonesty, in addition to the consequence for the original misbehavior. If your child admits to having made a mistake or poor choice, and does *not* attempt to deny involvement, make the child aware that you are reducing the overall consequence because he/she was honest with you right away. Remember, even if you are upset over what your child did, your goal is to increase the child's motives for being truthful.
- Be consistent. Always deal with the situation when you know the child has told a lie. Lies that go unpunished encourage the child to lie more in the future.
- Do not reward honesty unless you are certain that this is the case. Unidentified lies may be reinforced by your reward. When you are certain that the child is telling the truth, let him/her know how much you appreciate the truthfulness. Give your child more attention when you know that he/she is being honest.
- Inform the child's teacher(s) of your concerns. Keep in regular contact with school personnel. Let the teacher(s) know if something unusual has happened to the child which could be construed as a lie. Make your child aware of the ongoing communication between home and school.

What Can I Do as a Teacher?

In addition to the suggestions listed for parents, the following classroom considerations may be helpful:

- Document the instances when you know the child has told a lie. Include what the child lied about, what happened before and after he/she lied, and how you know what was said was untrue. Share this information with the parent/guardian(s) and together develop a plan for curbing this behavior. Keep the family informed of the child's progress regularly.
- Increase the child's opportunities for positive attention and interactions.

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- If you are unsure whether or not the child is telling the truth, do not engage with the child or give him/her attention. Make a neutral comment and redirect the conversation. If the child persists with the story, let the child know that you may need to check with home to see if this is really the case.
- Lead classroom discussions and classroom presentations on the importance of honesty and trust. Demonstrate how easy it is to destroy trust built up over years with one lie. Discuss the social consequences of lying.
- Determine the consequence for an uncovered lie, for example, a certain number of minutes owed at recess and a phone call home. Calmly deliver the consequence and follow through consistently.

Resources

If further information and/or assistance is desired, contact the school psychologist/guidance specialist at the child's school. Resources outside the school include community mental health centers and other private practice professionals. Additional reading material can be found below:

Ekman, P.E. (1989). *Why kids lie: How parents can encourage truthfulness.* New York: Penguin Books.

McCarney, S.B., & Cummins Wunderlich, K. (1993). Lies, denies, exaggerates, distorts the truth. *The pre-referral intervention manual* (pp. 374-375). Columbia, MO: Hawthorne Educational Services, Inc.

Martin, M. , & Waltman-Greenwood, C. (1996). *Solve your child's school-related problems.* New York: Harper Perenniel.

Sprick, R.S., & Howard, L.M. (1995). Lying. *The teacher's encyclopedia of behavior management: 100 problems/500 plans* (pp. 445-455). Longmont, CO: Sopris West.

Stokes, T.F., & Osnes, P.G. (1991). Honesty, lying, and cheating: Their elaboration and management. In G. Stoner, M.R. Shinn, & H.M. Walker (Eds.), *Interventions for achievement and behavior problems* (pp. 617-631). Silver Spring, MD: National Association of School Psychologists.

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Nailbiting

A Handout for Parents

**by John M. Hintze, University of Connecticut
and Jeannine M. Hintze, West Hartford Public Schools**

Background

Nailbiting is a frequent and persistent behavior among children and adolescents. Although quite common, nailbiting can be an extremely difficult habit to modify. Estimates suggest that between the ages of 4 and 6, approximately 38% of all children bite their nails. By the age of 10, estimates increase to approximately 60% and for males peaks at age 13, when 62% of them bite their nails. Nailbiting appears to taper off for females at about the age of 11 when 51% report that they engage in the behavior. Following adolescence, nailbiting decreases to 20% in college-age men and 19% in college-age women. Into adulthood, the incidence of nailbiting stabilizes at approximately 10-20%.

While normally considered a harmless enough habitual behavior, acute paronychia (inflammation of the tissues adjacent to the nail, usually accompanied by infection and pus formation) can occur. Indeed, well over 80% of patients requiring surgical treatment for acute paronychia are biters or pickers. Even in its mild form, nailbiting can produce minor cosmetic problems such as bloody cuticles and often leads to social stigma characterized by mild repugnance in parents, teachers and friends.

Development

Theories as to why nailbiting occurs are far reaching. For example, some have viewed the development from a Freudian perspective, suggesting that nailbiting is a form of self-punishment due to a guilt complex or a symptom representing repressed, destructive or sexual impulses and their punishment. Others have suggested that nailbiting is a means of reducing tension under conditions of situational stress. While such theories were quite popular in years gone by, contemporary views of nailbiting most often point to learning theory as the basis for the development and maintenance of the behavior. That is, nailbiting is simply a learned and acquired behavior that has no deep emotional disturbance. Indeed, such an explanation is supported by the fact that there is no evidence for symptom substitution once the behavior is eliminated.

What Can I Do as a Parent?

In general, nagging, shaming, or scolding the child about a nailbiting habit is more likely to aggravate the habit than to help it. Nonetheless, before intervention attempts are made, parents need to carefully consider a number of factors that may be associated with their child's nailbiting. For example, how long has the child bitten his nails? Has the behavior been relatively persistent and enduring or is it a recent occurrence? If the latter is true, has there been any significant changes in the life of the child that may better explain the behavior (e.g., recent move, divorce, serious illness, etc.)? If so, there is a chance that once various life circumstances stabilize there may be an associated reduction in nailbiting. Are there any patterns as to when and where the child bites his/her nails? For example, is it mostly when watching TV, riding in the car, when playing with peers, etc.? Identifying situations when the child does and does not bite her nails can be extremely enlightening and an important part of an intervention. Finally, what things have been tried in the past? If nagging and badgering have proven ineffective, scratch them off the list and try to refrain from using such strategies.

Children who are motivated to stop biting their nails will probably find success in at least one or a combination of the following strategies:

Self-monitoring. Self-monitoring is simply a system whereby individuals observe and record their own behavior. Most children over the age of 8, and some younger, are capable of noting and recording the frequency of nailbiting. On a notecard, the child is instructed to make a tally mark each time he/she bites his/her nails or puts a finger in his/her mouth. Older children may also be encouraged to jot down what they were doing just before they started to bite their nails. Studies have shown that just recording the frequency of a problem behavior is often effective in reducing it. The act of noting and recording behavior seems to lead to an increased awareness and evaluation of one's behavior with changes observed in a positive direction.

Positive reinforcement. In combination with self-monitoring, once an average number of nail-biting episodes is determined, parents in conjunction with their child can set goals for improvement (e.g., from 7 episodes a day down to 5). If the child meets his/her goal for the day, positive reinforcement should be provided. Reinforcers can vary from praise to small gifts such as a special pencil, to picking out a favorite desert. In choosing reinforcers it is more important that it is something that will help keep the child on course for improvement rather than its size or value. Often improved appearance of the hands is enough to keep children motivated. In addition, parents should provide praise and encouragement (and a surprise tangible reward will help too) when the child *isn't* biting his nails. The importance of *not biting one's nails* cannot be undersold. This will also aid in drawing to the attention of the child that he/she is able to go a long time without biting their nails.

Competing response. Since you can't bite your nails while you are doing something else, the child can be instructed to perform a competing activity whenever the urge to bite her nails occurs. For example, the child can be taught to put her hands down by her side and clench her fist until she can feel the tension in her hands or arms. Repeating the sequence of actions for 2-3 minutes following the temptation to bite her nails can be very effective. Other competing responses include rubbing worry beads, squeezing silly putty or any activity that involves the hands in an acceptable manner. Once again, the child should be reinforced for employing such strategies either by the parent or alone, for not biting his nails.

Aversive techniques. Although once very popular, strategies such as coating the nails with a bitter substance like iodine or valerian or use of restraints such as mitts or artificial nails are not recommended. While such short-term strategies are very effective, a significant problem lies in the fact that they never teach the child adaptive behaviors or encourage coping strategies on the part of the child. In most instances, once the aversive substance is removed increases in nailbiting is resumed. As equally if not more important toward reducing nailbiting is the replacement of an appropriate behavior. Aversive techniques fall short in that they never foster the acquisition of adaptive behaviors that serve as alternatives to nailbiting.

Resources

Azrin, N. H., & Nunn, R. D. (1977). *Habit control in a day.* Old Tappan, NJ: Simon & Schuster.

Martin, M. & Waltman-Greenwood, C. (Eds.). (1995). *Solve your child's school-related problems* ("Nervous Habits," pp. 167-172). New York: Harper Perenniel.

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Name-Calling

Intervention Strategies for Parents and Educators

by H. Marie Boultinghouse
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Background

Name-calling is one of the most destructive behaviors which students bring to or develop within the school setting. This "skill" appears to be developed early in life and it may be practiced within the home between siblings or even by the children's parents. Those who are most hurt by name-calling resort to using it against others. Name-calling leads to retribution, both by name-calling and other types of unkind, hurtful behaviors, sometimes culminating in physical violence. Unfortunately, many adults also engage in name-calling, having never learned more appropriate means of expressing anger and displeasure; we have only to view the evening news to see the consequences — often violent death.

Name-calling is a means of expressing displeasure/disapproval of others. Its aim is to hurt the other person, at least verbally, or facilitate the other person's getting into trouble as he/she retaliates in kind. This kind of retaliation firmly cements into place the reinforcing consequences; thus, name-calling begets name-calling, resolves no problems, and often leads to accelerated destructive behaviors.

The person who is in the best position to stop name-calling is the recipient of name-calling; this is the person who is in a position to reinforce or fail to reinforce the "fun" of name-calling. Although parents and teachers try to discourage it, they are rarely effective in stopping it — once the adult is no longer present. Since the purpose of name-calling is to make the person feel angry, hurt emotionally, or to get him/her into trouble as the consequence of his/her response, the recipient can totally change this into an enjoyable experience for oneself and effective discouragement of the name-caller. The situation is defused because no reinforcement is available; the name-caller is amazed and often goes away shaking his/her head in disbelief or confusion, unable to retaliate in any fashion. Thus, the victim becomes the victor — wonderful for one's self-esteem and without retaliating in kind.

Children have forever been told to ignore name-calling; yet, this rarely, if ever, happens with children and often doesn't happen when name-calling occurs between adults or between adults and children.

What Can I Do as a Parent or Teacher?

A few steps describe the entire process and ca be easily undertaken after sufficient practice in the use of role playing/behavior rehearsal and the use of imagery. The first step is to establish eye contact with the name-caller; this means appropriate eye contact and not hostile staring. The second step is to get oneself into a state of calmness; this is essentially attained by the use of deep breathing, counting slowly to five, and slow exhaling and/or imaging oneself in a totally relaxed state. The third step is related to the first two: speak in a voice appropriate to the surroundings; lowering the voice is helpful in maintaining control of oneself as well as getting the attention of the name-caller.

Carrying out the first three steps sets the stage for execution of the fourth step which involves dealing directly with the content provided by the name-caller. Several strategies are helpful; some involve no use of spoken language, some involve combinations of strategies, and others involve partial "agreement" since there may be a grain of truth in the name-caller's assertion.

While maintaining appropriate eye contact and a state of calmness and speaking in a lowered voice:

1. Say "Thank you," I'm glad you noticed," "Thank you for pointing this out," or "You really made my day."
2. Shrug your shoulders.
3. Combine the "Thank you" and shrugging one's shoulders.

When children/adults are very serious about really upsetting the other person, they often bring outsiders into the assertion, such as "your mama is...." In this case, the victim can easily say, "She is really glad that you noticed." Another procedure is exaggerating the situation; this can really be fun. For example, a person teased about wearing glasses might say, "Did you know that these glasses give me x-ray vision and I can see your liver?" Children are quite proficient in making up their own responses along similar lines.

One can also admit any "grain of truth" in the name-caller's assertion. Since we all have been stupid *at least* once, we can truthfully say, "Yes, I sometimes do something and feel a bit stupid afterwards."

The major challenge in learning/practicing these strategies to stop name-calling is to counter the child's conviction that they won't work; providing a "bet" of some sort helps to provide motivation. Encouraging the former "victim" to keep a record of the outcome is also helpful.

Summary

The use of name-calling is destructive both to the recipient and the name-caller; it often results in retaliation, thus escalating the situation, and sometimes leads to physical violence. The skills described are easily taught, learned and practiced; they include role playing, behavior rehearsal and the use of one's imagination. The former "victim" easily becomes the "victor" as the name-caller's power vanishes. The faithful use of these strategies will stop name-calling, the intention; yet it does not accelerate the situation, thereby honoring the personal/professional "bottom line" of not making the situation worse.

Resources

Garrity, C., et al. (1994). *Bully proofing your school.* Longmont, CO: Sopris West.

Kaufman, G. & Raphael, L. (1991). *Stick up for yourself.* Minneapolis, MN: Free Spirit Publications.

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Self-Control Skills for Children

A Handout for Parents

by Louise K. Eckman
Penn State University

Overview

Normally, children learn self-control as they grow through the preschool and elementary school years. Learning when to talk and when to be quiet, when to run and when to sit is a big part.of growing up. It is important for children to learn these childhood behavioral lessons — not to hit peers, not to have tantrums when one cannot get one's way. For some children, these lessons will come easily. Others may not learn them without help from teachers and parents.

What is self-control? Self-control is a skill that enables the child to suppress undesirable, inappropriate behaviors and act in socially acceptable ways. It enables him or her to "decide" how to act and to choose a good course of action. Children are not born with self-control — it is a learned skill. Two and three-year-old children may hit others or scream when frustrated, but as the years go by, repeated messages from caring parents convince them to change their behavior and handle frustration differently.

How do children learn self-control? Many children learn self-control by watching other children and adults. If they see other, older children handling frustration by saying, "oh, darn it", and trying again, they may slowly begin to tone down their reactions and imitate an admired big brother or sister. By age 10 or 12, few children are hitting or screaming in response to frustration. Children are eager to please parents, teachers and peers by behaving in acceptable ways

However, there are significant numbers of children who do not learn very well by watching others. They will learn more effectively through direct teaching along with the use of rewards and consequences. They will need consistent teaching from parents on handling frustration. This teaching will help them to control their reactions and substitute more effective responses.

Teaching Self-Control

It is important to select age-appropriate goals for the child to whom you wish to teach self-control. (It will be very helpful if the older children in the family as well as any adults present have good self-control.) Engage the child's cooperation by discussing goals with him or her. Encourage him or her to join you in a project to improve behavior in specific ways. *Try one simple goal first*, and choose one at which the child is likely to succeed. Later, other goals can be worked on. Some sample goals for different ages:

Age 5	**Age 7**	**Age 9**
not interrupting	going to bed on time	starting homework independently
reducing number of fights with siblings	not hitting	coming to dinner on time

What strategies will work? Once a specific goal has been chosen, a strategy should be selected which will help the child accomplish his or her goal. The strategy should show the child what to do *instead of* reacting in a undesirable way. Some of the following might work:

- **Take a break:** decrease fighting and hitting by encouraging the child to "take a break" — getting away from a sibling or peer when a fight might begin

- **Set bedtime or mealtime:** being on time for meals or bedtime can be encouraged by agreeing upon a time for each and reminding the child when the time comes.
- **Teach and provide attention:** not interrupting might be encouraged by showing a child how to watch for a time when others are not talking, so they can get into the conversation; it will be important to give the child plenty of attention so that he or she is not "starved for attention."
- **Use rewards:** The key to success lies in rewarding the child consistently for progress made. You might want to discuss rewards with the child beforehand. Praise and attention are important rewards. Many children consider time alone with a parent an important reward. Without rewards, the plan for change might not succeed. So it is important to get the child's cooperation, make it clear what change is desired, and reward the child promptly when success occurs.
- **Use self-regulation programs:** Once the child has experienced some success in achieving self-control, a self-regulation program might be tried. Self-regulation should be used only when other self-control goals have been successfully accomplished, and only if the child wants to try self-regulation. The steps are the same — gain the child's cooperation through discussion (planning the change), select a goal, select a strategy and plan the reward. With self-regulation, the parent assists the child with step one — planning for change, and step four — providing reinforcement/reward.The parent might also want to help the child select strategies. It is important for parents to be interested and support this process.

Resources for Parents

Colorosa, B. (1994). *Kids are worth it: Giving your child the gift of inner discipline.* New York: Wm Morrow.

Dinkmeyer, D. & McKay, G. (1989). *Systematic training for effective parenting.* Circle Pines, MN: American Guidance Service.

Joslin, K. (1994). *Positive parenting from A to Z.* New York: Ballantine Books.

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Self-Control Skills for Children

A Handout for Teachers

by Louise K. Eckman
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Overview

Normally, children will learn self-control as they progress from kindergarten through high school. Learning when to sit, when to stand, when to talk, when to keep silent, and how to handle situations with peers is a big part of growing up. For some children these lessons will come easily; others may not learn self-control without planned intervention from teachers and parents.

What is self-control? Self-control is a skill which enables the child to suppress undesirable, inappropriate behaviors, and act in a socially approved way. It enables him or her to "decide" how to behave, and choose a good course of action. Children are not born with self-control; it is an acquired skill.

How do children learn self-control? Many children learn self-control by watching other children. Through observation and practice, they learn how to behave. They are often eager to behave well and earn the approval of teachers and peers. However, there are a significant number of children who do not learn self-control readily by observing others. They will learn more effectively through direct teaching with the use of rewards and consequences.

Teaching Self Control

It is important to select age-appropriate goals for the child to whom you wish to teach self-control. Engage the student's cooperation by discussing goal area(s) with the student. Encourage him/her to join you in a project to improve his/her behavior in specific ways. Try one simple goal at first, where the probability of success is high. Then other goals can be added. Some examples:

First Grade	Third Grade	Fifth Grade
stay in seat	do not talk while others are talking	ignore those who are teasing
raise your hand to speak	stay out of fights	listen to directions

What strategies will work? Once behavioral goals have been identified, a strategy for teaching self- control should be selected. Some classroom management ideas for children to help develop a sense of control are listed below:

- **Use prompts:** seat the student near the front of the class where prompting can be carried out unobtrusively; remind the student of the new goal by using a pre-arranged signal — a touch on the shoulder or a hand signal
- **Review student progress frequently:** let him/her know how he/she is doing
- **Enlist the cooperation of parents**
- **Reduce distractions:** keep manipulative materials away from the learner unless he/she needs them for a specific learning activity
- **Help students make transitions:** always follow a stimulating activity with a quiet time (resting head on desk, for example) to help students learn how to shift gears

- **Use flexible work spaces:** some students may work better on the floor, than at a desk
- **Teach attending skills:** students can be taught to fold hands together or put them in pockets when quiet attention is needed
- **Contracts:** use contracts to specify desired behavior
- **Avoid embarrassing student:** avoid verbal attacks or commands in front of other students
- **Use reinforcement:** The key to success is in reinforcing the student consistently for progress made. You might want to discuss reinforcement with the student in advance. Praise and attention are the most important reinforcers. Other possible reinforcers might be an extra privilege in the classroom, or a treat provided by parents.
- **Use self-regulation programs:** Once the student has experienced some success in achieving self-control with this teacher-conducted approach, a self-regulation program might be tried. Self-regulation should be used only when other self-control objectives have been achieved, and only if the student shows interest in changing his/her behavior more independently. The steps are the same — gaining the student's cooperation through discussion, selecting a goal, selecting a strategy and planning for reinforcement. With self-regulation, the teacher assists the student with step one, planning for change, and step four, providing reinforcement.

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Spanking: Alternative Discipline Strategies

A Handout for Parents

by Maureen Lynch
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Background

Parenting is one of the most humbling things we do. All the "I will never . . ." we promised while watching others struggle raising their children suddenly crumble. Yet most professionals and parents agree that one "I will never . . ." we're wise to keep is the resolve to never spank. When a child is spanked, no one wins. Anger is provoked by the hitting — in both the parent and the child. The child feels badly and may misbehave even more. Often a distance develops between parent and child.

Studies have shown that spanking can cause negative long-term effects. Children raised in homes with a lot of physical punishment turn out to be more anti-social and egocentric, and physical violence becomes the accepted norm. It is important that we remember we are raising someone's future spouse and future parent. The evidence is really overwhelming. The hundreds of studies done all come to the same conclusions: spanking doesn't work; spanking often results in later violent behavior; the more children are spanked, the more likely they will be abusive toward their own children.

When you make the promise to yourself that you will never spank, that promise can hold you steady at times of embarrassment, frustration and exhaustion — all times when it is easy to turn to spanking. Those who rely on spanking are at a disadvantage because they never develop other more appropriate techniques to use with their children.

What Works?

The focus of this handout is on children ages two to ten. During the first two years, your best strategies will be mainly distracting and redirecting. After age ten, children begin to enter puberty and both the problems and the approaches may change.

Prevention is always best, of course. Taking the time the time to learn about your child's level of development can sometimes help you prevent misbehavior. If you learn what is realistic to expect for your child's age, you may be able to prevent behavior problems. Some time spent observing your child will also tell you a lot about his or her temperament and quirks. There may be times of the day or specific activities that just cause too many problems. After a busy morning of errands that meant getting in and out of the car a half a dozen times, that last stop at the grocery store may not be worth the melt down it will probably cause. A better move would be to go home for lunch and a nap, and to pick up the groceries later.

Yet even with the most sensitive parenting, there seem to be certain inevitable battlegrounds — the car, bedtime, etc. Here are some suggestions for helping your child behave better without having to resort to hitting or spanking. These are taken from *The Discipline Book* by William and Martha Sears. Readers are encouraged to look at the book for a more detailed description.

Clear Talking

A major part of discipline is learning how to talk to your child. The situation and the child will help you decide what approach to take. You'll never want to use all of these at once. But here are some things to try:

1. **Connect first** — Get to eye level and maintain eye contact before giving directions.
2. **Use the name** — Begin with your child's name: "Amy, please . . ."
3. **Make it brief** — You may want to keep it to one sentence. The longer you ramble the more likely your child will think you're wavering.

4. **Stay simple** — When your child gets the glazed look you can be certain you are no longer being understood.
5. **Repeat** — Ask your child to repeat the directions back to you. If s/he isn't able to, you will know they were too complicated or too long.
6. **Make it irresistible** — To avoid power struggles you can remind a toddler about the advantages of doing what you want: "Ethan, when you're finished getting dressed we can go outside to play."
7. **Be positive** — Instead of "No screaming !" try "Use your inside voice." Or make up a whispering game.
8. **Begin your direction with "I want"** — This seems to work well with children who don't like being ordered but want to please. "I want" or "I need" allows the child to respond to a request rather than an order.
9. **When . . . *then*** — This sounds like you expect obedience and reminds the child of the advantages of completing the task. For instance, "When you finish brushing your teeth, we'll read some stories."
10. **Give choices** — Questions like "Yellow shirt or purple one ?" "Which toys do you want in the tub?" can help a child become interested in the task at hand.
11. **Speak correctly-developmentally** — Asking a very young child why they did something isn't very helpful. You could instead say, "We need to talk about something you did." Likewise the younger the child, the simpler and the shorter the commands and the comments should be.
12. **Speak correctly-socially** — Speak to your child the way you want them to speak to you. Help them learn that good manners are expected, not just an option.
13. **Psychologically** — Threats or heavy reprimands put children on the defensive. Likewise it is helpful to avoid a leading question when a negative answer is not an option. "Would you like to . . . ." can be replaced with "Please . . . ."
14. **Write it down** — Reminders can easily sound like nagging to an older child. You can communicate reminders with a pad and pencil, even put on a funny sticker.
15. **Help the child calm down** — The louder the child yells, the softer you should respond. If you come in at the loud level you will have two tantrums to deal with. So be calm and be the adult for your child. Sometimes just having a listener will help the tantrum wind down. Nothing will sink in if the child is falling apart emotionally.
16. **Replay the message** — Very young children will need to have the directions repeated but preteens regard repetition as nagging.
17. **Let your child complete the thought** — Instead of telling your child not to leave their room a mess, try "Where do you want to keep your soccer stuff ?"
18. **Rhyme rules** — "If you hit, you must sit" is a good way to teach rules. Ask your child to repeat it after you.
19. **Give appealing alternatives** — Even though going alone to the park is not allowed, playing in the neighbor's backyard could be OK.
20. **Encourage the use of words** — "Use words to tell me" can be a reminder to not scream or whine.
21. **Advance notice** — An announcement like, "Five more minutes and we're leaving" can make departures seem less abrupt.
22. **Close the discussion** — When a matter is closed for discussion let your child know. It will save wear and tear on both of you. Use your "I mean business" voice to say, "I'm serious about this. I'm not changing my mind."

Discipline Strategies

1. **Praise** — Sometimes it seems like you have to work hard to catch your child being good. But it's worth the effort since praise is a very effective way to influence your child. It's a good idea to get in the habit of

praising the behavior and not the child — "I like the way you put your clothes away. Your room looks great !" Praise tends to lose its power if expected behavior gets showered with praise. So it's important to keep it genuine and fresh — a thumbs up when passing a doorway, a post- it on a pillow or in a lunch box.

2. **Selective ignoring —** Many parents have an unspoken agreement to ignore small things, behavior that is annoying but does no harm to people or to property. In order for this to really work, you have to be making the time to acknowledge desirable behaviors. Remember you're ignoring the misbehavior, not the child. Not getting dragged into squabbles about toys helps the child respect the parent's job description — "I don't settle petty arguments." Practicing your selective ignoring skills also helps prepare you for the challenges yet to come — teenagers' dress and moody behavior.
3. **Time out —** Some people call this quiet time or thinking time. Time out works best if it is used to shape behavior rather than punish it. It stops misbehavior and gives both the child and the parent time to reflect. Once again in order for it to work you need to give a lot of "time in". Make sure you have prepared your child so they connect the behavior with the time out. Some families have a time out place such as a stool in the kitchen. It's important that you stay cool and avoid yelling as you escort the child to the time out area. The time should be brief, about one minute per year of age. Keep time out quiet. You may want to use a stove timer or alarm clock. It might be helpful to ask the school psychologist about a specific time out approach to use with your child. Just remember, after time out is over, it's over. The time has been served and it's best to get on with the day.
4. **Teach understanding of consequences —** Children learn self-discipline by experiencing the consequences of their choices. We all learn best from our own mistakes. The trick, of course, is to prevent dangerous and expensive mistakes. Whenever possible, assuming this won't be dangerous or expensive, state your opinion then back off and let the consequence teach your child. Slowly the child learns to take responsibility for their behavior.
5. **Motivating —** Reward charts, certificates, and other prizes are all ways to set limits and get jobs done. Work with your child. Let your child help make the chart and make daily entries.
6. **Reminders —** A reminder can be a look when a child is about to misbehave, or a short verbal cue that jogs a child's memory about something that needs care. Written reminders are appreciated by youngsters who don't like to feel controlled.
7. **Negotiating —** If used wisely, negotiating improves communication between parent and child, and helps children develop confidence in their viewpoint while learning how to stand up for their rights. You need to make it clear what things aren't negotiable. Also important are a tone of respect when negotiating. If the session becomes a yelling or whining one, you will need to remind your child that a house rule is that you are the parent and not to be talked to in that tone. Now the negotiations are over for today.
8. **Withdrawal of privileges —** This technique works best when it is naturally connected with the behavior. If you ride your tricycle into the street you lose it for the rest of the day. If you miss the morning carpool you must walk to school, etc. The child needs to know the rule ahead of time so it doesn't seem like an arbitrary move on the part of an angry parent.

The Alternative: Good Discipline

Coming up with discipline strategies is a very personal decision based on your parenting style, your child's age and temperament, and the problems themselves. Parenting, being what it is, you'll develop a great system only to find that your child is on to new situations that require different responses from you. But no matter what your child's age, one of the best gifts you can give them is the chance to grow up with both respect and limits, exactly what a good discipline program will offer.

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Stealing

Suggestions for Parents and Teachers

by Judy Johnson
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Background

Studies show that most children admit to having taken something that is not theirs. Research has shown that there are two different types of stealing: confrontive, in which a child confronts the victim and may use force, and non-confrontive, in which the child does not confront the victim and force is not a factor. For many youth, stealing is an isolated incident, but for others it continues into adulthood. As far as involvement in the legal system, youth are responsible for 25% of all of the thefts in the United States. Research also suggests that children and adolescents who steal are at greater risk for adjustment and legal difficulties later in life.

According to the literature, some family characteristics associated with stealing include poor parental supervision and discipline; tension in the home or other family stressors (e.g., abuse, divorce, domestic violence, unemployment); and parents' indifference toward stealing. Children who experience inconsistent discipline don't learn to associate their behaviors to predictable social consequences, and often become self-centered and socially detached. Children may also learn to steal and other delinquent behaviors from family members.

Development and Causes

Stealing is usually an early signal of other problems. It is often a way for a child or adolescent to display unhappiness, confusion or insecurity. Other reasons why juveniles steal may include peer pressure, risk taking, excitement, poor impulse control, to support a drug habit, or to meet an immediate need or desire.

Peer pressure may contribute to a child's stealing because she or he may be easily influenced by the group or be unable to think independently. In addition, many adolescents may steal in order to maintain membership in a peer group because they have feelings of insecurity or confusion.

Many children enjoy taking risks and different children have different levels of desire for those activities. The need for "thrill seeking" or excitement depends on the child's background and personality. In general, children are often impulsive and find it difficult to control their strong emotions. Often, stealing is an impulsive act by a child who gave little or no thought to the consequences of his actions. Impulsive children also have difficulty dealing with peer pressure. Usually, children become less impulsive as they grow older.

What Can I Do as a Parent?

- Be sure that you and your child agree that stealing is not to be tolerated.
- If it happens, respond in a calm, matter-of-fact style.
- Take any stealing incident seriously, and never allow your child to profit from stealing.
- Problem solve with your child more acceptable ways to meet his/her needs.
- Support your children, but require them to pay any restitution for the theft.
- Emphasize to your child why he/she should not steal, as well as the possible consequences of stealing.
- Consider individual and/or family counseling if problems continue.

What Can I Do as a Teacher?

- Respond to the situation in a calm fashion.
- Avoid labeling the student as a thief and deal with the taking of belongings privately rather than publicly.
- Assess the level of stealing, what is being stolen, and how often the stealing occurs.
- Communicate with the student's family to create ways the child can earn things that they would otherwise take.
- Have the student's parents mark all of the child's belongings. If needed, check the student's belongings at time intervals. The child is praised for having only his/her belongings or consequated for having stolen items.
- Make sure the student understands the consequences of stealing (e.g., pay for items he/she takes from others).
- Encourage all students to keep track of their own belongings and restrict students from bringing unnecessary items to school.

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Tantrums

An Intervention Guide for Parents

by Theo Lexmond, NCSP
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Background

Temper tantrum behavior in preschool-aged children is common. Researchers have observed that 50 to 80% of preschoolers demonstrate one or more temper tantrums per week. Temper tantrums can include relatively mild behaviors such as pouting, whining, crying and name-calling, as well as more disruptive behaviors such as screaming, kicking, punching, scratching and biting, and even self-injurious behaviors like head banging and holding one's breath to the point of fainting.

Temper tantrum behavior is a part of the normal development of young children. Typically, the development of tantrums is only a temporary stopping point along the path of learning how to cope with frustration. For some children, however, temper tantrums become a block to further emotional growth and maturity. Researchers have documented that tantrum behavior that becomes habitual in early childhood is related to adjustment problems later in life.

Children rarely have temper tantrums when they are alone. Tantrums occur, almost exclusively, in the presence of other people. This suggests that the answer to dealing effectively with temper tantrums lies in examining how caregivers and tantrum-prone children interact before, during and after a tantrum has occurred.

Development

The world is an exciting place for toddlers. Their ability to crawl, and later to walk, allows them to reach and explore any area they can see. Toddlers are constantly getting into things that their parents would prefer they left alone. In addition to their improved mobility, toddlers also grow rapidly in their ability to understand and use words. The growth of their vocabulary allows them to understand simple commands and begin to express their needs. The combination of these two factors, increased ability to move around and increased understanding of words, leads to an event that toddlers find very frustrating — the introduction of verbal rule training by their parents.

Verbal rule training is the flood of necessary do's and don'ts that parents shower upon their toddlers in order to protect them from harm and keep them out of mischief. "Don't touch!" "Don't go in there!" "Don't hit!" "Don't cry!" "Do eat your carrots." "Do be quiet." "Do put that away." "Do be good." These are just a few examples of the many commands that toddlers face each day.

Though infants learn to talk instead of gurgling and babbling, they never give up smiling, laughing, frowning and crying as ways of communicating how they feel. Crying and screaming by a two or three-year-old communicates frustration in a way with which the youngster is familiar. The experience of verbal rule training can be very frustrating for toddlers. In response to this frustration, toddlers will often revert to screaming and crying to proclaim to the world that they are "fed-up." An occasional outburst of screaming and crying by a two or three-year-old child is not an uncommon or worrisome occurrence. A child of this age finds it hard to accept brief frustrations and putting these frustrations into words is an equally difficult task.

When Should Parents Worry About Tantrums?

The best way to answer this question is to take a close look at your child's tantrum behavior and the behavior of you and your family when tantrums occur. Do any of these things happen in your family?

- Your child has tantrums in many settings, not just at home.
- Your child has tantrums regardless of who in the family is caring for the youngster.
- Your child is having more and more tantrums each day as time goes by.
- Your child's tantrums are becoming more severe as time goes by.
- Your child hurts him or herself or tries to hurt others during tantrums.
- Your child receives a great deal of extra attention from family members when a tantrum occurs. For example, when your child has a tantrum someone hugs or holds the child, or perhaps someone scolds or lectures the child.
- Members of your family try to stop your child's tantrums by giving the youngster what he or she wants.
- Members of your family avoid taking a tantrum-prone child grocery shopping, to church, to visit friends or relatives, out to eat, etc., because they are afraid the child will tantrum in those settings.
- You find it hard to get someone to babysit your tantrum-prone child.

If one or more of the items above describe the experience your family is having, your child may be developing a severe tantrum problem. This can develop in several ways: 1) Children can learn to use tantrums as a tool to get things that they need and want; 2) they can model the tantrum behavior of people they see around them; 3) they can develop tantrums as a response to delayed language skill development; or 4) they can develop severe tantrums as a consequence of a medical disorder. Each of these possibilities will be explained in turn.

Severe Tantrums as a Learned Response: The most common way that tantrum behavior becomes a severe problem is when children learn that they can use tantrums to get things that they want. When children first develop tantrums, they use crying and screaming as a way of expressing frustration. Tantrums start out as a way for children to communicate that they are "fed up" with the limits placed upon them. If children learn, however, that having tantrums can gain them extra attention from their family or can allow them to do things they would not otherwise be allowed to do, their tantrums will come to serve a different purpose. No longer will they use tantrums simply as a means of expressing frustration. Instead, such children will use tantrums as a tool for obtaining more attention and getting to do more things. Tantrums will have become goal-directed.

Often, without realizing they are doing so, family members and other caregivers cause tantrums to become goal-directed. If a child, for example, cries and screams because he desires a toy that is currently out of reach, hugging and rocking the child until he is calm will soothe the youngster for the moment, but may encourage him to cry and scream in the future when something else he wants is out of reach. Even though he was not given the toy as a result of his tantrum, he received a great deal of special attention. By repeating this pattern over and over again, family members and caregivers actually teach a child to have tantrums as a way of obtaining something the child wants. This is not to say that children should never be soothed when they are upset. The key point to remember is that children should not be allowed to use tantrums as a way of getting special treatment from those around them. Learning to use tantrums as a way to obtain desired goals is by far the most prevalent cause of severe childhood tantrum behavior.

Severe Tantrums that Develop from Modeled Behavior: Besides learning to use tantrums as a way to obtain special treatment from caregivers, there are other important, though less common, ways in which a child can develop a severe temper tantrum problem. Children who live in an environment where violent behavior is prevalent may model that behavior. A young child, for example, who regularly sees her parents engaged in bouts of screaming and crying may mimic the behavior of her parents when she becomes upset. Parents and older children are powerful models of behavior for young children.

Severe Tantrums and Language Delay: Another way in which tantrum behavior can become a severe problem is when a child fails to develop age-appropriate language skills. Children who experience a history of ear infections and diminished hearing in early childhood, for example, sometimes demonstrate delayed language skill development. Without the ability to understand words well or to express themselves in words these children may experience the world as an intensely frustrating place. Children who develop a severe tantrum problem and who have a known history of hearing difficulty and language delay should be evaluated by a speech and language clinician to determine whether language therapy is appropriate.

Severe Tantrums and Other Medical Disorders: There are a number of medical disorders affecting children that may, as a consequence of their symptoms, contribute to the development of severe tantrum behavior. Conditions that broadly impact the development of children such as Fetal Alcohol Syndrome, Autism, Pervasive Developmental Disorder, Down Syndrome, Williams Syndrome and Seizure Disorder, among others, may impact children in such a way that the emergence of a severe tantrum problem becomes more likely. Children who exhibit a medical condition that causes developmental delays and who show signs of severe temper tantrum behavior should be evaluated by an appropriate medical specialist.

What Can I Do as a Parent?

Whether tantrum behaviors are just beginning to develop in your child, or tantrums have become a long standing problem, there are actions you and members of your family can take to help your child gain control over tantrum behavior:

When Tantrums First Develop

- *Rule out a specific cause:* Rule out the possibility that tantrums are being caused by a factor other than general frustration with verbal rule training. Some factors which may cause or contribute to tantrums include teething, the side effects of some medications, a sudden emotional loss such as the death or long absence of a loved one, an undiagnosed hearing loss, delayed language skills, or other developmental medical conditions. In the vast majority of cases, tantrums are the result of frustration encountered in daily living. If a specific cause, such as one of those mentioned above is suspected, you should have your child evaluated by an appropriate health care professional.
- *Examine the routines of your child's life:* Young children need a consistent daily routine in order to feel secure. Being awakened, fed, bathed, played with and put to bed at relatively consistent times provides security. Children who cannot predict at all when daily events are likely to occur feel insecure and express more frustration with their world than children who experience a consistent daily routine.
- *Examine the limits that are placed upon your child's behavior:* Either a failure to provide limits on the behavior of a young child or providing limits that are far too strict and severe for a young child's age can erode security and increase the frustration that a child will experience and express. All children need consistent limits on their behavior in order to feel secure. The limits placed on children must be appropriate for their age.
- *Examine your own emotional response to the tantrum behavior:* In order to help a child overcome tantrum behavior, it is important that you have your own emotions under control. Some tantrum behavior is fed by the emotional responses that the tantrums bring out of others. Strive to stay on an emotional "even keel" when your child loses emotional control and has a tantrum.
- *Do not inadvertently reward your child for tantrum behavior:* Do not allow your child to receive extra attention from family members or to obtain things he or she would not otherwise be allowed to obtain as a result of having a tantrum. Tantrums are not an appropriate way of asking for a desired object. Even if the object is something your child would normally be allowed to have, do not allow the child to obtain it by having a tantrum. Provide the object only when the child is calm and has asked for it in an appropriate fashion, considering the child's age and abilities.

- *Do not scold or spank your child for having a tantrum:* Scolding or spanking is likely to reinforce tantrum behavior and cause it to get worse.
- *Do not ignore your child when the youngster is behaving appropriately* because you are afraid of "setting the child off" and causing a tantrum to occur. Pay extra attention to your child when he or she is behaving appropriately and is not having a tantrum.

When the Tantrums are a Serious, Long-standing Problem

- *Seek professional help:* If tantrum behaviors have become a severe problem for your child, arrange to visit with a child behavior professional such as a school psychologist or clinical child psychologist. A trained child care professional can help you develop a program that will deal with the specific circumstances of your child's situation. Tantrum behaviors that are deeply entrenched do not yield to quick-fix solutions. A child behavior professional can help you develop a comprehensive plan for dealing with severe tantrum behavior and can demonstrate the special skills you will need in order to help your child get tantrums under control. There are effective techniques available for dealing with tantrums that occur at home, in school, in public areas such as grocery stores and restaurants, and for dealing with bedtime tantrums as well.
- *Don't scold or spank:* As mentioned earlier, you should not scold or spank your child for having a tantrum. Scolding or spanking is likely to reinforce tantrum behavior and cause it to get worse.
- *Control your own emotions:* Adults who lose control of their emotions while dealing with an out-of-control youngster show the same behavior to the child that they want the child to stop. If you find it impossible to keep yourself from becoming upset when your child loses emotional control, obtain support for yourself first. It will be very difficult for you to help your child if your child is controlling your emotions.
- *Try to pay extra attention to your child* when he or she is not having tantrums. By making yourself available when your child is behaving well, you teach your child that special attention can be gained by a means other than having tantrums.

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Time-Out

Guidelines for Teachers

by Thomas S. Ewing, Ph.D., NCSP
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Overview of Time-out

Time-out is defined as the withdrawal of opportunity to receive positive reinforcement or the loss of access to positive reinforcers for a specified period of time (e.g., 1-3 minutes). The effect is to reduce the future occurrence of the undesired behavior. There are three important features in this definition: (1) the discrepancy between the time-out environment and the normal "time-in" setting; (2) the loss of access to reinforcement contingent upon the undesired behavior; and (3) a resulting decrease in the future probability that the undesired behavior will recur.

Contrary to popular reasoning, time-out is not accomplished by simply moving an individual to a secluded setting. Such a method may accurately describe isolation, but is it by no means the only way in which time-out can be used.

Time-out Strategies

Two important factors for successful time-out include providing contrast to the time-in environment and being consistent in applying the strategies. The following ten steps should help establish an effective model for implementing time-out procedures to reduce undesired behaviors:

Step 1

Be able to precisely define the behavior you would like to decrease or increase. Example: *The child will decrease the number of times he speaks without raising his hand.* Or: *The child will increase his compliance with teacher given directions.* The definitions need to be as specific as possible.

Step 2

To change the misbehavior, you need to understand why it is being performed. First, observe the child in the setting where the misbehavior occurs. Now look for three things:

- Who pays attention to the misbehavior?
- What type of reinforcement does the child receive for this behavior? (This may include laughing, pointing, looking at, even being yelled at)
- Does the behavior help the child avoid or escape from something he/she may not want to be involved in?

When the child is in the regular or time-in environment, the level of reinforcement can be judged as lean, moderate, or rich. If it is rated as rich, this would mean the child is receiving lots of positive reinforcement (e.g., verbal or physical praise). If the environment is considered lean, the child is receiving very little reinforcement. Moderate would be considered somewhere between lean and rich.

Step 3

For time-out to be an effective intervention, make sure the time-in environment where the undesired behavior occurs would be rated as rich. This serves two purposes: it motivates the child to desire the time-in setting, and it serves as a severe contrast to the non-enriched time-out environment.

Step 4

Warnings about possible consequences generally are not needed if the desired behavior has been pre-taught. If a warning is given, it should be briefly stated (five words or less) without emotion, one time. Any more than this may result in what is called secondary gain. In other words, talking to the child my reinforce and therefore maintain the behavior you are trying to eliminate.

Step 5

When time-out is to be implemented, you do not need to explain "why" to the child, especially if desired behaviors have previously been explained. In the event that a reason is given, it is necessary to follow the same guidelines as stated in Step 4 above.

Step 6

To reduce the occurrence of undesired behavior, time-out may be implemented at two levels:

- **Non-exclusionary time-out**. This is where you remove reinforcers from the child. There are two levels of non-exclusionary time-out. They are:
    - (a) *Planned ignoring:* This occurs when social reinforcers — usually attention, physical conduct, or verbal interaction — are removed for a brief period of time (10-60 seconds) contingent upon the occurrence of an undesired behavior.
    - (b) *Removal of reinforcement:* When an undesired behavior occurs, you remove materials the child is interacting with for a period of time (1-3 minutes).
- **Exclusionary time-out**. This is where you remove the child from the reinforcing conditions. Non-exclusionary time-out is less intrusive and should be tried first. Exclusionary time-out has three levels. Listed from least to most intrusive, they are:
    - (a) *Contingent observation:* Here the child is moved from the time-in environment to another location and still observes ongoing or instructional activities. They may not, however, participate in them. Optimal time limits are 30 to 60 seconds.
    - (b) *Exclusion time-out:* Child is removed totally from the time-in environment. The child does not observe ongoing activities. Examples of exclusion are sitting behind a partition or sitting in a corner. Maximum effective time is up to two minutes.
    - (c) *Isolation time-out:* At this level of time-out the child is isolated from all probable reinforcers by being placed in a different room. Isolation requires a previously defined time duration. Generally five minutes should be the longest a child is isolated.

When preparing to implement a time-out procedure, one factor must be taken into consideration: Time-out will *not* work if the child sees it as an *escape.* Example: The child does not want to work on a math test, so he begins talking very loudly. In turn the teacher places him in time-out. This is rewarding to the child because he has avoided or escaped from a situation he didn't want to be in.

Step 7

In order to enforce a time-out, an adult should always be present. The child should NOT be the one responsible for determining when they are released. There are four general methods of enforcing time-out:

- **"Shaping"** involves observing the child in time-out and determining how long she can comply, (or "handle" it), then releasing her just short of her maximum tolerance. For example, if you want the child in time-out for two minutes, but find that after 45 seconds he starts making noise, next time release him after 40 seconds. Then in the future, extend the time in small increments until you reach the desired time.
- **"Put back"** is just as it sounds — you keep putting the child back (in the event they have left) into the time-out setting until the child has been in time-out for the desired time.

- "**Holding**" is a method of physical restraint. Because of possible injury to the child or the person holding them, this should only be implemented by persons properly trained to do so.
- "**Barrier**" involves a room from which the child in time-out cannot leave. Because of space limitations and possible legal or ethical issues, this is rarely used in regular school settings.

Step 8

The maximum duration of any time-out setting should be about five minutes. If there is a significant history of longer time-outs, then up to 15 minutes may be utilized.

Step 9

In deciding when to release a child from time-out, there are two common philosophies. Either the student must exhibit the desired behavior for a certain length of time, or the student must serve the entire pre-determined time duration.

Step 10

When the time-out is completed and the child is to be released, again minimize secondary gain. Use either a very brief verbal prompt (such as the child's name and the phrase "time-in") or a physical prompt (such as a touch on the shoulder or a flashing of the lights) to release the child.

Remember, the two most important guidelines to success with time-out are 1) provide contrast to the time-in environment and 2) be consistent in implementation.

Resources

Gast, D. L. and Nelson, C. M. (1977). Timeout in the classroom: Implications for special education. *Exceptional Children,* 461-464.

Nelson, C. M., & Rutherford, R. B. (1983). Timeout revisited: Guidelines for its use in special education. *Exceptional Education Quarterly, 3,* 56-67.

Rhode, G., Jenson, W. R., & Reavis, H. K. (1993). *Tough kid book: Practical classroom management strategies.* Longmont, CO: Sopris West.

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NATIONAL
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Verbal Aggression: Coping Strategies for Children

A Handout for Parents

by Janet H. Pitt, NCSP
Baltimore County Schools

Overview

Does your child complain that he or she is bullied? Gossiped about? Teased? Picked on? Interpersonal conflict is an inevitable part of life. Teaching children to deal positively with conflict, especially when it involves verbal aggression (or threatened physical aggression), is one of the greatest gifts that we can give them. Some of the suggestions below can be used with children as young as pre-schoolers. Others should be taught to elementary age children and definitely be part of their coping skills by the time they get to middle school when instances of insults, teasing, ugly rumors and hurtful name-calling escalate. Why does verbal aggression increase at this time? Usually, it is because many children react to the stress of greater peer pressure and confusion about their identity by taking their anger out on others.

In recent years, there has also been an increase in verbal disrespect by children of *all ages* in our society. Both parents and teachers report seeing more rudeness among young people, possibly due to a breakdown of values or greater stress in families.

When children do not have effective skills for coping with verbal aggression, they may respond in ways that increase interpersonal conflict and, perhaps, even endanger their safety. For example, some young people may physically fight back, resulting in injury and the possibility of revenge and more fighting at a later time. If the fighting occurs on school grounds, the student could be suspended, even if he (she) claims self defense.

Other children may respond to verbal aggression with retaliatory verbal attacks which result in both parties feeling more angry and hurt. Still, other children may respond to verbal aggression by becoming overly fearful and withdrawn. They may even avoid school or social situations as a way of escaping from peers who threaten or tease them.

What Can You Do as a Parent?

First, make sure that your child is not fueling the conflict by making hurtful remarks or counter insults. Make sure that he (she) is not using aggressive gestures or words that provoke others. Then try the following and give time for learning to occur:

Teach your child to avoid peers who are bothering him or her:
- Tell your child that it is all right to walk away from an angry peer.
- Explain that walking away can be a sign of strength, not weakness.
- Never criticize or belittle your child for avoiding a potential fight.

Explain that the unkind peer is the one with the problem:
- The bully or gossiper may be unhappy, confused or insecure.
- He/She may even be the victim of someone else's aggression.

Teach your child to use verbal assertiveness: Examples include:
- "I don't like how you're talking about me. Please stop."
- "I don't want to fight. It's not worth it to me to get suspended."

Role play how to agree or use "fogging" responses to put-downs (then walk away):
- "Thanks, I love compliments."
- "Hard to believe, isn't it?"
- "Old clothes are in, better go out and buy some!"
- "It's not in fashion to be in fashion, didn't you know?"
- "If we all had good clothes, you wouldn't have anyone to tease."

Explain that we all have control of our reactions to verbal aggression:
- We can choose to ignore it and not do anything at all.
- We can choose not to feel angry or hurt (not let our buttons get pushed).
- If we automatically get upset when we receive an ugly comment, we are allowing the other person to have power over us!

Teach your child to use positive self-talk when she/he is the victim of insults:
- "I'm okay. My opinion of myself is more important than what he (she) thinks."
- "I like myself. What he says about me and my family doesn't matter."

Give your child a sense of personal power by constantly building self esteem:
- Remind her of her personal strengths.
- Praise and hug him each day.
- Avoid reminding her of past failures or bad behavior.
- Take time out of your schedule to get him involved in activities that will improve his talents or help him build friendships with others.

Be an advocate for using respectful language and behavior in your home:
- Screen T.V. shows and turn off programs that emphasize physical or verbal aggression.
- Model good communication skills such as: calm exchange of ideas, listening with respect to the feelings and opinions of others, and using weekly family meetings to discuss family plans and responsibilities.
- Ask yourself: Do I use sarcasm, put downs, or critical remarks when I'm angry? If so, do I have to learn to be more tactful when expressing disapproval to my children and other family members?

Encourage your child to use peer mediation: If your child's school uses a Peer Mediation program, encourage your child to participate to deal with peers who create conflict related to verbal aggression.

For continuing or very severe problems, get involved yourself:
- If the problem is at school, contact an administrator, counselor, teacher or school psychologist. Arrange a conference to discuss the problem and possible solutions. Set a time for a follow-up discussion.
- If the problem is in the neighborhood, request to meet with parents of the aggressive child. Stay calm and aim for solutions, not blame.

Resources

Garrity, C., et al. (1994). *Bully proofing your school.* Longmont, CO: Sopris West.
Goldstein, A., et al. (1994). *Student aggression.* New York: Guilford Publications.
Huggins, P. (1993). *Helping kids handle anger.* Longmont, CO: Sopris West.
Kaufman, G. & Raphael, L. (1991). *Stick up for yourself.* Minneapolis, MN: Free Spirit Publications.
Martin, M. & Waltman-Greenwood, C. (1995). *Solve your child's school-related problems.* New York: HarperPerenniel.
Second Step: A violence prevention curriculum (1990). Seattle, WA: Committee for Children.

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NATIONAL
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Asthma in Children

Information for Parents

Health and Wellness

by Steven E. Curtis, Utah State University
Revised by Catherine A. Fiorello, Ph.D., NCSP, Temple University

Overview

Nearly three million children under the age of 18 have asthma, a chronic disease characterized by shortness of breath, gasping, wheezing and chest tightness. Studies of asthma over time suggest that asthma is becoming more common and more severe. Asthma is the leading cause of school absences due to a chronic disease, with the average child with asthma missing about 7% of school time due to the disease. Children are more likely to get asthma than adults, and most children with asthma are diagnosed by age three. For unknown reasons, African-Americans are about three times as likely to get asthma as European-Americans, and they tend to get it more severely. Asthma may involve heavy medication usage, repeated emergency room visits, hospitalization and occasionally death. Asthma may negatively affect a child's school performance, social interactions, self-esteem, and psychological adjustment. Effective treatment will involve medical intervention, patient and family education, and self-management techniques. Knowledgeable teachers can provide appropriate accommodations and reinforce self-management skills to aid the child with asthma to be successful and happy at school.

Characteristics of Asthma

Asthma is a chronic respiratory condition resulting in a reactive disease of the airway; it can bet set off by various health and environmental factors. It occurs when the airways that carry air in and out of the lungs become narrowed or blocked. The airway can be narrowed when the surrounding muscles go into a spasm as an allergic reaction ("bronchospasm") or when the mucous membrane lining of the airway becomes inflamed or swollen. Asthma-related airway obstruction may reverse wholly or partially, spontaneously or with treatment. It is intermittent; attacks are not always experienced on a regular basis. Children may have attacks throughout the year or they may be confined to a specific season. Asthma is also variable; the overall level of severity varies from child to child, and specific attacks vary from a mild episode, involving only chest tightness or a slight wheeze, to "status asthmaticus," steadily worsening asthma. These characteristics of being reversible, intermittent and variable distinguish it from other respiratory illnesses.

Causes of Asthma: Asthma is caused by physical hyper-reponsivity of the airways. Asthma tends to run in families, but general health and environmental factors actually set the asthmatic reaction in motion. The prevalence and severity of asthma may vary depending on the child's gender, race and socioeconomic level of the household. Boys are more likely to have asthma than girls. Children living in poverty, especially African-American children, are more likely to develop asthma and are more likely to develop severe cases that require hospitalization. Asthma attacks occur when the child is exposed to certain conditions called "triggers." For some children, emotional reactions such as crying can serve as triggers for an attack, but asthma does not have an emotional or psychological cause.

Common Triggers of an Asthma Attack: Common triggers include allergens (such as dust, pollens, mold, animal fur or feathers or foods), irritants (such as cigarette smoke, pollution or cold air), medications (such as aspirin), exercise or overexertion, respiratory infections, emotional reactions (such as hard laughing or crying), and certain places or environments. Triggers vary from child to child and are usually identified by physicians who may take a history and perform skin tests. For some children, consistent triggers are not easily identified.

Mechanisms of an Asthma Attack: Asthma attacks occur when there is blockage in the airways. Exposure to a trigger causes tightening of the muscles surrounding the airways (bronchoconstriction), resulting in smaller airways and restricted airflow. In more severe cases, the airways may also secrete excess mucus, further blocking the airways. Wheezing is the sound of air being forced through the mucus in the restricted airways and is often audible from a distance. An asthma attack must be treated immediately. Remember that the experience may be frightening, especially for a young child.

Symptoms of an Asthma Attack: Symptoms may include wheezing, chest tightness, shortness of breath, coughing, pains in the chest, hunched shoulders, face perspiration and an uncomfortable look on the face. During an attack, several or all of these symptoms may be present.

Treatment

Medical Treatment of Asthma: Treatment consists of efforts to prevent and reduce attacks, and responding to attacks once they occur. Anti-inflammatory drugs, such as corticosteroids, cromolyn sodium, or nonsteroidal anti-inflammatory drugs, are used to prevent attacks. Bronchodilators (beta agonists, methylxanthines, and anticholergenics) are used during acute attacks to open blocked airways rapidly, usually through an "inhaler" or a "nebulizer" Nebulizers are more difficult to use and may require adult assistance. Antihistamines may also be used to control allergic reactions common to children with asthma, but are not generally helpful in controlling asthma itself. Asthma medications may have side effects that affect children's functioning. Effects to be alert for include memory difficulties, drowsiness, anxiety, depression and tremors.

Attack Prevention: Attack prevention involves identifying and avoiding known triggers, recognizing early signs of an attack, and acting on early signs to prevent more serious attacks. Children can be taught to be alert for warning signs of an asthma episode, such as coughing, tightness in the chest or an itchy throat. They may also be taught to use a "peak flow meter" to measure the level of airway obstruction and predict when an asthma attack is coming, even before symptoms can be felt. They can be also be taught to avoid known triggers. Self-management is very important to a child's sense of control, so encouraging the child's sense of responsibility is critical. Emphasize that asthma is a condition that can be effectively treated and controlled.

Attack Management: Attack management involves these steps: relaxation, drinking warm liquids and using medications as prescribed. When early signs of an attack are noted, the child should stop any activity, sit down and rest for at least 10 minutes. During this time it is helpful for the child to engage in some type of relaxation technique. The child should slowly drink warm liquids in order to help the airways relax. Medication should also be taken as prescribed. If these procedures bring little or no relief, parents should contact their physician. If the child experiences ongoing shortness of breath and difficulty speaking, urgent medical care should be sought.

What Can I Do as a Parent?

Many children have undiagnosed asthma which could be treated if diagnosed by a physician. If you have noticed symptoms of asthma in your child, you should contact your health care provider.

If your child has been diagnosed with asthma, make sure the child's teacher knows the following: the physician's recommendations, the type and frequency of medication, possible side effects of medication, warning signs, use of the peak flow meter, specific triggers to avoid, behavior to expect from the child during an asthma attack, specific strategies to be used to prevent and manage attacks, and procedures to follow in case of the need for medical intervention.

If you feel that your child's asthma is affecting educational performance (because of the illness itself, side effects from medication, or excessive absences), a referral should be made to the school psychologist. Children with asthma may be eligible for special education services due to their health impairment. In addition, the school psychologist may be able to suggest direct interventions (teaching relaxation techniques, for example) that will help minimize the impact of the illness.

The focus of asthma intervention is to teach the child self-management strategies. You may need to monitor and remind the child of what should be done, if necessary, while being supportive and reassuring. Pay particular attention to prescribed times for medication, warning signs, use of the peak flow meter, triggers, and attack management procedures. Even very young children can be taught to take an active role in the management of their asthma.

You should alert for possible side effects of medication. Possibilities include memory difficulties, drowsiness, anxiety, depression and tremors. If these side effects are noted, you should contact the child's physician.

If the child has exercise-induced asthma, the child should follow medical procedures recommended prior to exercise. The child with asthma should not avoid exercise; rather, the child should exercise on a regular basis and take medications as prescribed to prevent an attack.

If an attack occurs, follow the general management procedures listed above or the procedures recommended by your physician. When a child's condition has improved after an attack, the child can resume normal activities.

When to call the doctor: If you have any doubts about the severity of an attack, call your physician. You should also contact your physician if the attack does not improve after intervention, if the child's lips or fingernails are turning blue, or if the child is breathing shallowly and focusing all attention on breathing. Immediate medical care may be necessary!

Resources

The American Lung Association: Call 1-800-LUNG-USA

This organization has a variety of materials about asthma, including programs for children and teens. Contact your local office, or visit their home page at <http://www.lungusa.org> for more information.

The Asthma and Allergy Foundation of America. *ACT (Asthma Care Training) for KIDS.* (Available from the agency at 1302 18th St. NW, Washington, DC 20036.)

This is a training kit for children to learn about the causes and treatment of asthma and how to achieve better control of symptoms. Designed for children 6-12 years of age and their parents.

Buchanan, N. , Cooper, P., & McQuitty, J. (1995). *Childhood asthma: What it is and what you can do.* Tenspeed Press.

Clear and concise information for parents and teachers is presented regarding causes, diagnosis and treatment. The book includes food triggers, desriptions of drugs, guide to resources, crisis plan ideas and ways to explain asthma to children.

The National Heart, Lung, and Blood Institute (1989). *Learn Asthma in Seven Days.*

This is a self-management guide that also includes tips for parents who want to teach their children to control their asthma. Many other materials are available in English and Spanish. Contact the National Asthma Education and Prevention Program (1-301-251-1222) for more information.

Plaut, T. F. (1988). *Children with asthma: A manual for parents.* Amherst, MA: Pedipress.

This book is an excellent resource for parents. The worries and concerns of parents are addressed, and stories about children and their families are included. Also, basic information about asthma and medication is presented.

Steinmann, M. (1992). *A parent's guide to allergies and asthma.* New York: Dell (Children's Hospital of Philadelphia Series).

Basic information for parents about the causes, treatment, physical and emotional aspects of allergies and asthma, including a chapter on environmental avoidance techniques.

Weiss, J. H. (1994). *Breathe easy: Young people's guide to asthma.* New York: Magination Press.

This book is designed for children ages 12 and under. It includes basic information about asthma in a simple, easy to understand way. This would be a good resource for the child with asthma.

Wood, R.A. (1995). *Taming asthma and allergies by controlling your environment.* Washington, DC: Asthma and Allergy Foundation of America.
A brief monograph to help parents and children minimize exposure to allergens at school and at home.

Some of the above information and resources from "Allergies and Asthma" by Drs. Gretchen Meyer and Nathan Blum (Children's Seashore House, Philadelphia, PA), in Children's Needs II *(G. Bear, K. Minke, A. Thomas, Eds.), published by the National Association of School Psychologists (1997).*

The original handout was prepared by Steven Curtis of Utah State University (1992); revised by Dr. Catherine Fiorello, NCSP, Temple University (1998).

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Attack Management: Attack management involves these steps: relaxation, drinking warm liquids and using medications as prescribed. When early signs of an attack are noted, the child should stop any activity, sit down and rest for at least 10 minutes. During this time it is helpful for the child to engage in some type of relaxation technique. The child should slowly drink warm liquids in order to help the airways relax. Medication should also be taken as prescribed. If these procedures bring little or no relief, the child's parents should be contacted to discuss the possibility of physician referral. Urgent medical care may be necessary!

What Can I Do as a Teacher?

Many children have undiagnosed asthma which could be treated if diagnosed by a physician. Teachers observing children with symptoms of asthma should contact the parents. If the child has not been diagnosed, the teacher may suggest a medical referral.

If a child has been diagnosed with asthma, the teacher should contact the parent to discuss the following: the physician's recommendations, the type and frequency of medication, possible side effects of medication, warning signs of a coming attack, specific triggers to avoid, behavior to expect from the child during an asthma attack, specific strategies to be used to prevent and manage attacks, and procedures to follow in case of the need for medical intervention.

If the child's asthma is affecting educational performance (because of the illness itself, side effects from medication, or excessive absences), a referral should be made to the school psychologist.

Children with asthma may be eligible for special education services due to their health impairment. In addition, the school psychologist may be able to suggest direct interventions (teaching relaxation techniques, for example) that will help minimize the impact of the illness.

The focus of asthma intervention is to teach the child self-management strategies. The teacher should monitor and remind the child of what should be done, if necessary, while being supportive and reassuring. Pay particular attention to prescribed times for medication, warning signs, use of the peak flow meter, triggers and attack management procedures.

The teacher should be alert for possible side effects of medication. Possibilities include memory difficulties, drowsiness, anxiety, depression and tremors. If these side effects are noted, the parents should be notified so they can contact the physician.

If the child has exercise-induced asthma, the teacher should assist the child to follow medical procedures recommended prior to exercise. The child with asthma should not avoid exercise; rather, the child should exercise on a regular basis and take medications as prescribed to prevent an attack.

If an attack occurs, follow the general management procedures listed above or the procedures provided by the parents. When a child's condition has improved after an attack, the child should return to class.

When to call the parents or the doctor: If you have any doubts about the severity of an attack, call the parents immediately to discuss a possible visit to the physician. Parents should always be called if the attack does not improve after intervention, if the child's lips or fingernails are turning blue, or if the child is breathing shallowly and focusing all attention on breathing. Urgent medical attention should be sought!

Resources

The American Lung Association: Call 1-800-LUNG-USA

This organization has a variety of materials about asthma, including programs for children and teens. Contact your local office, or visit their home page at <http://www.lungusa.org> for more information.

Asthma and Allergy Foundation of America. *Managing asthma in the school: An action plan.* (Video) (Available from author at 1302 18th St. NW, Washington, DC 20036.)

Basic information about asthma for school personnel; ideas for working with physicians.

Buchanan, N. , Cooper, P., & McQuitty, J. (1995). *Childhood asthma: What it is and what you can do.* Tenspeed Press.

Clear and concise information for parents and teachers is presented regarding causes, diagnosis and treatment. The book includes food triggers, descriptions of drugs, guide to resources, crisis plan ideas and ways to explain asthma to children.

Mendoza, G. , Garcia, M.K. & Collins, M.A. (1989). *Asthma in the school: Improving control with peak flow monitoring.* Healthscan.

Brief summary of asthma prevention and treatment, including charts and handouts for teachers, school nurses and children.

Meyer, G. & Blum, N. (1997). Allergies and asthma. In G. Bear, K. Minke, A. Thomas, Eds. *Children's Needs II.* (pp.827-839). Bethesda, MD: National Association of School Psychologists. An overview of asthma and allergies and the impact on children's learning and school adjustment.

The National Heart, Lung, and Blood Institute (1989). *Learn Asthma in Seven Days.*

This is a self-management guide that also includes tips for parents who want to teach their children to control their asthma. Many other materials are available in English and Spanish. Contact the National Asthma Education and Prevention Program (1-301-251-1222) for more information.

Plaut, T. F. (1988). *Children with asthma: A manual for parents.* Amherst, MA: Pedipress.
This book is an excellent resource for teachers as well as parents. The worries and concerns of parents are addressed, and stories about children and their families are included. Also, basic information about asthma and medication is presented. One section of the book deals with school issues and problems.

Weiss, J. H. (1994). *Breathe easy: Young people's guide to asthma.* New York: Magination Press.
This book is designed for children ages 12 and under. It includes basic information about asthma in a simple, easy-to-understand way. This would be a good resource for individual children or for small groups.

Some of the above information and resources from "Allergies and Asthma" by Drs. Gretchen Meyer and Nathan Blum (Children's Seashore House, Philadelphia, PA), in Children's Needs II *(G. Bear, K. Minke, A. Thomas, Eds.), published by the National Association of School Psychologists (1997).*

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Cancer in Children

Information for Parents

by Deanie Campbell, Camilla, GA
and Andrea Canter, Ph.D., NCSP, Minneapolis Schools

Background

One in every 330 children in the U.S. develops cancer prior to the age of nineteen. Along with the child, parents and the siblings will be affected by cancer and will face obstacles in their efforts to help the child as he/she lives with the disease. Common forms of cancer among children include leukemia (the most common in childhood), Hodgkin's, Wilm's tumor, bone tumors, soft tissue sarcomas, Retinoblastoma (cancer of the eye), and brain tumors. Although some forms of cancer are typically fatal, many forms can be successfully treated if diagnosed early. Collaboration between family and health providers, and between family and school personnel can greatly enhance the young cancer patient's recovery and family adjustment.

Impact

Just as different types of cancers affect the child's body differently, the impact of the disease and the reactions to the diagnosis vary across the affected parties — the child, parents, siblings, friends and teachers.

Children: The child feels the physical effects of the disease — nausea, vomiting, weight loss, fatigue, problems with motoric control (fine and gross motor) and mood swings, as well as the psychological effects — fear, loneliness, anger, depression and reduced self-esteem. Almost all children, having learned that they have cancer, wonder initially if they are going to die. Younger children may also experience feelings of abandonment due to numerous hospitalizations; children younger than about age eight may have difficulty verbalizing their fears and other feelings. School-age children experience concerns about keeping up with their schoolwork and the reactions (or rejections) of their peers

In addition to the physical and psychological effects of the disease, the child has to contend with the effects of the treatments. The most often used treatments, singly or in combination, include surgery (i.e. removal of the cancer in an operation), radiation therapy (using high doses of radiation to kill the cancer cells), and chemo-therapy (using drugs to kill or prevent the growth of cancer cells). The side effects of these treatments include hair loss, scars, nausea, vomiting, amputations, etc. Preschool children may not be able to interpret the purpose of treatments and may believe they are being punished for bad behavior. Among adolescents, the physical consequences of treatment may produce high levels of anxiety over appearance and ability.

Parents: While the child deals with the physical and psychological effects of the disease, the parents are waging their own battles with denial, anger, guilt, grief, fear, frustration and loneliness. Parents often feel guilty that they cannot protect the child from this insidious disease and, as a result, often become overprotective in other aspects. In some cases, guilt also arises from the amount of attention, energy and finances that are directed toward the one child (with cancer) rather than for all the children in the family.

Siblings: The siblings of the child with cancer often have to deal with anger, grief and guilt. They may feel guilty because of any and all unkind words or deeds directed toward the sick sibling (which occur between *all* siblings at one time or another but loom large and ugly when cancer becomes involved). Also they may be confronted with embarrassment (upon overhearing remarks from other children about the sibling with cancer, perhaps due to an amputation or hair loss). This embarrassment may be joined by shame (at being embarrassed because they know that their sibling cannot help his/her condition) and anger (at the other children who make the remarks). Too, the siblings may feel shame because of resentment. They may resent all the attention the sibling with cancer receives from parents, grandparents, neighbors, etc; the amount of time the parent(s) spend with the sibling; the amount of money spent on the sibling (which makes less money available for the other children); the inability to have a family routine (due to scheduled and unscheduled trips to doctors and hospitals); the absence of parents from events involving them due to the sibling's illness. Siblings of cancer patients may exhibit behavioral difficulties (withdrawl or aggression) and physical symptoms.

Helping the Child With Cancer

How can the child, parents, siblings and friends overcome the impact of cancer? Adaptability is essential. Each affected individual must be able to understand the course of the disease and strive for normalcy to the greatest degree possible.

Become well-informed: The first and foremost rule for dealing with this disease is to be well-informed. Children with cancer are treated in a team approach (medical, family and school), and all members of the team must be equipped to answer questions and provide information. Specific information about the treatment and its side effects should be provided to school staff who work with the child.

Respect the rights of the child: The child has the right to know what is happening to his/her body as a result of cancer and its treatment. Without an explanation, a child will use his or her imagination and fear to explain symptoms. He or she may believe the illness is punishment. Telling the child the truth will help dispel guilt and alleviate anxiety, as well as increasing the child's cooperation with treatment. The amount of information provided should be tailored to the age of the child and the nature of the illness. It is important for school personnel to work with the child's parents regarding how much information the child has about the disease and its treatment and what is comfortable for the family to share with school personnel and classmates. See tips below for talking with children about their illness and treatment.

Seek support: The child needs permission and opportunity to express feelings. At times, your child will feel uncertain, anxious and fearful. He or she may not be able to express these feelings verbally, and may act out by becoming aggressive, loud or withdrawn, or have nightmares, bed-wetting or eating problems. At school, their behavior might become more problematic and they may not do as well in their schoolwork. Encourage play as a means of expressing feelings in a safe way — through puppets or drawings or dolls. Often, support from family alone is often not sufficient. If you notice significant changes in your child's behavior, be sure to talk about these symptoms with your child's doctor, school psychologist, social worker or counselor. Currently, group therapy is often recommended along with other forms of treatment because it is imperative to provide support for the child and family so that they do not feel isolated and overwhelmed.

What/How Should I Talk to My Child About Cancer?

Depending on your relationship with your child, you may feel that it is best for you to tell the child yourself, or ask the doctor to help explain cancer and its treatment. Even if you do not tell your child about the illness yourself, you or someone close to your child should be present to provide support and encouragement. Health professionals (doctor, nurse, psychologist) can help you determine what to say to your child. It might also help to first rehearse with someone close to you.

When? There is no right time to tell your child that she or he has cancer. You should have a quiet time where you can be alone with your child, and in a familiar setting if possible. The longer you wait after the diagnosis, the harder it will be to talk about it, and the more time your child will have to become anxious and fearful. Be sure you have information about the type of cancer and its treatment so that you can be prepared for questions and feel more confident that you have some answers.

Tailor information to the child's level of development: How much information is given and how to present it will depend on the child's age and maturity. A gentle, honest and open style usually works best. The following guidelines will give you some ideas about how to discuss cancer with children of different ages. You will need to use your own judgment and knowledge of your child to determine what will work best for your child and family:

- *Children under age two:* Babies and toddlers can't understand illness, but they will experience anxiety about separations from parents and about medical procedures and hospitals. After about 18 months, children understand enough to know what will hurt, so it is important to be honest. Give young children choices that don't interfere with treatment, such as choices about mixing medicine with juice or applesauce.
- *Children ages 2-7:* Children in this age range can understand illness to some extent but are very concrete and tie events together that are unrelated. For example, the child might connect his illness to some extraneous event such as misbehavior. During this developmental period, children become very rule-bound and may assume that feeling better is a matter of following certain "rules". It is therefore important to let children know that they did not do anything to cause the illness and that the illness and treatment are not punishment. Treatment should be explained simply but honestly. For instance, the illness can be explained as a "war" between "good guy" cells and "bad guy" cells, with the medicine designed to help the good cells get stronger to beat out the bad. At this age, children can talk about feelings in concrete terms; it is helpful to related feelings about cancer to familiar feelings and experiences. It is critical that children understand that it is OK to feel scared, to cry and to seek comfort.
- *Children ages 7-12:* Although still limited by their own experience, children in this stage understand relationships between events and are less concrete in their views of the world. They are more able to see that cancer is a set of symptoms and that treatment is intended to help them get better, and thus are more able to cooperate with treatment and doctor's "orders." Explanations can involve more detail but linking to familiar situations is still helpful. Cancer cells can be described as "troublemakers" that get in the way of the work of good cells, and treatment is designed to get good cells working together again. At this age, children will likely express concern about the effects of cancer on their ability to go to school and keep up with their classmates and on the status of their friendships. They will need reassurance that they will still be able to learn and play.
- *Adolescents:* Children over the age of 12 will usually be able to understand the complexities of the illness and its treatment and address issues in the abstract. While teenagers will consider illness on the basis of specific symptoms that interfere with their normal lives, they can also understand the reasons for the symptoms and subsequent treatments. They can understand an explanation of cancer as a disease that causes malfunctioning of cells creating abnormal growth, with the abnormal cells spreading to other parts of the body and disrupting normal functioning.

Keep communication lines open: Establish a climate where open communication is supported. This will help your child feel free to ask questions during the course of treatment, to express feelings and seek support as needed. It may be important to share your own feelings about the disease and its impact with your child in order to reassure him or her that you are available for support despite your own sadness, frustration and anger. Keeping your child informed of the progress of treatment will help your child to feel like a member of his or her health team. Sometimes older children are asked to sign a "pediatric assent" form — this describes treatment and your child's signature means that he or she understands the treatment and agrees to cooperate with it. It also helps the child feel free to ask questions and participate in decisions.

Questions Children Ask

Why? Why me? It is important that children understand that cancer is not their fault. It is a disease and even the experts aren't sure why it happens.

Will I die? Will I get well? Children have often heard of a family member or neighbor who died of cancer and naturally fear that they too will die. It is important to acknowledge that cancer is a serious illness, but that there are many treatments that will be tried to make him or her well. Knowing that many people are involved in treating the cancer will help the child feel more secure.

What will happen to me? Initially, children may be frightened by the many new procedures, doctors and other cancer patients they see at the hospital. They may develop unrealistic fears about treatment. It is very helpful to explain treatment in advance, including descriptions of side effects and how they will be helped when these occur. The child should be told that there are many types of cancer and what happens to one person won't necessarily happen to another. A calendar showing the treatment and appointment schedule will help the child track his progress and anticipate any changes.

Why do I have to take medicine? Often, children feel well and therefore don't understand why they must take medication. Younger children might understand the notion that "bad cells are hiding" and that medicine will help keep the bad cells from growing or coming back.

What will I tell other kids? Particularly if the child misses a lot of school or returns with obvious physical changes (loss of hair, weight loss or gain), they will be concerned about the reactions of classmates. Encourage your child to stay in touch with classmates or friends while away from school. Encourage your child to be honest about the illness and treatment, and to assure peers that they can not "catch" the disease like a cold or the flu. Help your child anticipate that others may treat him or her differently at first — because they don't know much about cancer or because it scares them. Reassure your child that good friends will continue to be good friends.

Tips to Reassure Your Child

- Remind your child that neither cancer nor its treatment are punishments
- Be honest in your explanations. It's OK to say "I don't know."
- Ask your child questions — about what he or she thinks, feels.
- Let your child know it is OK to cry and feel sad.
- Set limits. Children will likely challenge your rules during their illness, but they really need the reassurance that things are "normal" so routines and expectations should change as little as possible.
- Let the child have appropriate control over things that will not impact health or treatment; living with many restrictions can give children a sense that they have no control at all.
- Keep a sense of humor: With an illness requiring frequent poking and prodding with needles and more intrusive instruments, it is essential to be able to find humor whenever and wherever possible.
- Try to maintain normal routines: To the extent possible, family and school routines should be maintained to give the child and family the security of a "normal" environment. Encourage contacts with friends, completion of homework and follow-through with appropriate responsibilities.

Activities that help them remain connected to their classroom and classmates are essential — letters, tapes, visits (as medically feasible). The school nurse, social worker or psychologist can help facilitate such activities.

- Encourage activities that help reduce anxiety, such as drawing, role playing
- Encourage "family talks" to reduce anxiety and provide mutual support
- Remember that there will be good days and bad days
- Remember that the health care team can answer questions and give support
- Younger children will need extra reassurance when facing separations due to hospital treatment

Resources

American Cancer Society: 3340 Peachtree Rd NE, Atlanta GA, 30326. (National organization providing services and resources regarding prevention and treatment of cancer in adults and children.)

Bracken, J.M. (1986). *Children with cancer: A reference guide for parents.* Oxford University Press.

Fromer, M.J. (1995). *Surviving childhood cancer: A guide for families.* American Psychiatric Press.

National Cancer Institute. *Talking with your child about cancer.* NIH Publication #91-2761. (Available from the NCI Website at *<http//cancernet.nci.nih.gov/>* or contact National Cancer Institute, NIH, Building 31, Room 10A24, Bethesda MD 20892. Other NCI publications about children with cancer are available. NCI also sponsors a toll-free Cancer Information Service (CSI). You can reach a CSI office by calling 1-800-4-CANCER (1-800-422-6237). CSI can answer questions in English or in Spanish.

Websites

National Cancer Institute
<http//cancernet.nci.nih.gov/>

Oncolink
<http//www.oncolink.upenn.edu>
[An online cancer resource site sponsored by the University of Pennsylvania; includes information for physicians, health professionals and patients.]

The True Heroes Project
<http://members.aol.com/TrueHeroes>
[This project designed to offer school based interventions for children with cancer who are going back to school. Visit the web page or e-mail Anthony Paolitto, Ph.D. and Beth Levy, M.A., C.A.G.S. at <TrueHeroes@aol.com>]

Some of the information in this handout comes from the NCI publication "Talking with your child about cancer." Thanks to Beth Levy, school psychologist in Braintree, MA, for her review and suggestions.

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Cancer in Children

Information for Educators

by Deanie Campbell
Camilla, GA

Background

Cancer is a disease of both adults and children, in which some of the body's cells grow abnormally, invade other cells and can spread to other parts of the body, disrupting normal body functions. Although some forms of cancer are typically fatal, many forms can be successfully treated if diagnosed early. Common forms of cancer among children include leukemia (the most common in childhood), Hodgkin's, Wilm's tumor, bone tumors, soft tissue sarcomas, Retinoblastoma (cancer of the eye), and brain tumors. In addition to the physical consequences, cancer spreads beyond the physical well-being of the child to cause psychological damage as well as damage to the family unit. Although the child is the identified patient, the entire family unit is at risk.

With approximately seven thousand new cases of cancer diagnosed in children each year in the United States, cancer continues to be the number one disease killer of children ages one year through adolescence. As one in every 330 children in the U.S. develops cancer prior to the age of nineteen, it is very probable that educators — teachers, psychologists, counselors, etc. — will at some time work with children with cancer. Along with the child, the parents and the siblings, the educators will be affected by the cancer and will face obstacles in their efforts to help the child as he/she lives with the disease.

Impact

Just as different types of cancers affect the child's body differently, the impact of the disease and the reactions to the diagnosis vary across the affected parties — the child, parents, siblings, friends and teachers.

Children: The child feels the physical effects of the disease — nausea, vomiting, weight loss, fatigue, problems with motoric control (fine and gross motor) and mood swings, as well as the psychological effects — fear, loneliness, anger, depression and reduced self-esteem. Almost all children, having learned that they have cancer, wonder initially if they are going to die. Younger children may also experience feelings of abandonment due to numerous hospitalizations; children younger than about age eight may have difficulty verbalizing their fears and other feelings. School-age children experience concerns about keeping up with their schoolwork and the reactions (or rejections) of their peers

In addition to the physical and psychological effects of the disease, the child has to contend with the effects of the treatments. The most often used treatments, singly or in combination, include surgery (i.e. removal of the cancer in an operation), radiation therapy (using high doses of radiation to kill the cancer cells), and chemo-therapy (using drugs to kill or prevent the growth of cancer cells). The side effects of these treatments include hair loss, scars, nausea, vomiting, amputations, etc. Preschool children may not be able to interpret the purpose of treatments and may believe they are being punished for bad behavior. Among adolescents, the physical consequences of treatment may produce high levels of anxiety over appearance and ability.

Parents: While the child deals with the physical and psychological effects of the disease, the parents are waging their own battles with denial, anger, guilt, grief, fear, frustration and loneliness. Parents often feel guilty that they cannot protect the child from this insidious disease and, as a result, often become overprotective in other aspects. In some cases, guilt also arises from the amount of attention, energy and finances that are directed toward the one child (with cancer) rather than for all the children in the family.

Siblings: The siblings of the child with cancer often have to deal with anger, grief and guilt. They may feel guilty because of any and all unkind words or deeds directed toward the sick sibling (which occur between *all* siblings at one time or another but loom large and ugly when cancer becomes involved). Also they may be confronted with embarrassment (upon overhearing remarks from other children about the sibling with cancer, perhaps due to an amputation or hair loss). This embarrassment may be joined by shame (at being embarrassed because they know that their sibling cannot help his/her condition) and anger (at the other children who make the remarks). Too, the siblings may feel shame because of resentment. They may resent all the attention the sibling with cancer receives from parents, grandparents, neighbors, etc; the amount of time the parent(s) spend with the sibling; the amount of money spent on the sibling (which makes less money available for the other children); the inability to have a family routine (due to scheduled and unscheduled trips to doctors and hospitals); the absence of parents from events involving them due to the sibling's illness. Siblings of cancer patients may exhibit behavioral difficulties (withdrawal or aggression) and physical symptoms.

Teachers may be affected by the instability caused by the disease (e.g., the child is at school on Monday, but out for the rest of the week; the child seems to feel well and can complete most of his/her work today, but tomorrow cannot complete half). The teacher has to deal with physical and psychological manifestations of the disease as they present themselves in the classroom. For example, when the child becomes physically ill, perhaps nauseous and vomiting, the teacher must be prepared to handle this. If the child becomes withdrawn or behaves aggressively, the teacher has to be prepared to provide interventions as needed (and as age-appropriate for the child), perhaps talking and listening to the child, contacting the counselor/psychologist to talk with the child, contacting the parents, or allowing the child some time to regroup in a prearranged special place in the school.

Helping the Child With Cancer

How are the child, parents, siblings and educators to work within the confines of cancer? Adaptability is essential. Each affected individual must be able to understand the course of the disease and strive for normalcy to the greatest degree possible.

- ***Become well-informed:*** The first and foremost rule for dealing with this disease is to be well-informed. Children with cancer are treated in a team approach (medical, family and school), and all members of the team must be equipped to answer questions and provide information. Specific information about treatment and its side effects should be provided to school staff who work with the child.
- ***Respect the rights of the child:*** The child has the right to know what is happening to his/her body as a result of cancer and its treatment. The child also needs permission and opportunity to express feelings. The amount of information provided should be tailored to the age of the child and the nature of the illness. It is important for school personnel to work with the child's parents regarding how much information the child has about the disease and its treatment and what is comfortable for the family to share with school personnel and classmates.
- ***Keep a sense of humor:*** With an illness requiring frequent poking and prodding with needles and more intrusive instruments, it is essential to be able to find humor whenever and wherever possible.
- ***Try to maintain normal routines:*** To the extent possible, family and school routines should be maintained to give the child and family the security of a "normal" environment.
- ***Seek support:*** Currently, group therapy is an adjunct to other forms of treatment because it is imperative to provide support for the child, the parents and the siblings so that they do not feel isolated and overwhelmed. The educator may seek support by consulting with other educators who have worked with students with cancer.

Resources

American Cancer Society: 3340 Peachtree Rd NE, Atlanta GA, 30326. (National organization providing services and resources regarding prevention and treatment of cancer in adults and children.)

National Cancer Institute. *Talking with your child about cancer.* NIH Publication #91-2761. (Available from the NCI Website at *<http//cancernet.nci.nih.gov/>* or contact National Cancer Institute, NIH, Building 31, Room 10A24, Bethesda MD 20892. Other NCI publications about children with cancer are available.)

Oncolink: An online cancer resource site sponsored by the University of Pennsylvania; includes information for physicians, health professionals and patients. *<http//www.oncolink.upenn.edu>*

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Chronically Ill Children

A Handout for Parents

by Margaret L. Potter, Ph.D.
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Background

Most childhood illnesses last for only a few days or at most, several weeks. However, 10 to 20 percent of all children have chronic illness where the treatment may continue for years. For two percent of these children, the illness is severe and regularly interferes with daily activities. There is a wide variety of chronic illnesses, of problems associated with such illnesses, and of reactions to the illness on the part of the child, parents, teachers and friends. Because each situation is unique, it is important to be able to be creative and flexible when dealing with problems that do come up.

Development

Depending on the specific illness, the severity and effects of a chronic illness may change as the child grows older and as the body goes through normal maturational changes. Especially during adolescence, previously routine treatments may need to be changed both because of the adolescent's changing body and because of the teen's increasing need for independence, responsibility and privacy. Also changing as the child grows older is the child's understanding of illness:

Birth to 18 months — Infants do not realize that illness is not a part of normal life. Very young children do not understand that objects and people still exist even when they cannot see them, thus separations from family may be especially painful.

18-36 months — Toddlers understand their illness only as something that interferes with their own world. They have a magical view of causes and effects leading them to believe that if they want something to happen it will happen; or they may believe it was something they thought or did that made them sick. Toddlers also need to feel that they have some control over their world.

3-7 years — Preschoolers are beginning to think more logically, but still tend to believe that bad things, like being sick, result from wrong doing, outside forces, or events that happened close together in time or location. They define illness by what they can actually see or feel and may develop conflicting theories about their illness.

7-12 years — Elementary school-aged children still understand best that which they can feel or see. By about age nine or ten, they start to understand some of the unobservable active processes of their bodies, but they tend to believe firmly that it is germs that cause illness. At about age 11 or 12 they start to understand the body's own healing process.

Adolescents — Adolescents are increasingly capable of understanding the complexities of how their body operates. Some teens may take an intellectual view of their illness and try to learn as much as possible about it. They may develop their own personal ideas about illness combining emotion, fact, fantasy and even, still a measure of self-blame. Adolescents may also assert their independence by refusing or sabotaging treatment routines.

What Can I Do as a Parent?

Experts agree that it is best to treat chronically ill, even terminally ill, children as normally as possible. Be matter-of-fact about the illness. As much as possible, maintain normal age-appropriate expectations for your child including completion of assigned household and school responsibilities. Do not let the illness overshadow the person, or overtake your family.

Whenever possible, let your child/adolescent assume responsibility for their own care and have a say in that care. This helps them feel as if they have some control over their lives. Even toddlers can be given choices about which cup to drink their medicine from or whether to take it before or after putting on their pajamas. Adolescents should be treated as active partners in treatment and educational decisions.

Help your other children to develop their own identities and to understand the similarities and differences between themselves and their ill sibling. Tell them about the illness at a level they can understand and keep them informed about what is happening.

Find a contact person in the school whom you can keep posted about any changes in your child's condition or treatment. Since teachers change, a more logical contact person might be the school nurse, counselor or assistant principal.

Keep communication channels open. Work closely with all of the people involved in your child's care. Do not be afraid to ask questions or to ask to have information repeated.

Get to know other families that are also dealing with a chronic illness. If there are no organized groups near you, ask your school or doctor to suggest someone with whom you and your child can share problems and experiences.

If your child's progress in school is hampered by the illness, he or she may be eligible for special services under federal and state laws. Check with your school — services available may include hospital/homebound tutoring, physical and occupational therapy, classroom assistance, counseling, etc.

Work with the school to develop a written plan of how to deal with make-up work, schedule modifications, emergency situations and so on.

Recognize that it is normal for you and your child to periodically feel frustrated, angry, sad, anxious, guilty, or even to deny the seriousness of the illness. Just try not to let these feelings interfere with your child's treatment plan.

Resources

Closer Look, National Information Center for the Handicapped, Box 1492, Washington, D.C. 20013.

The Exceptional Parent — A monthly magazine providing practical information and articles for parents of children with special needs. Your local library should have a copy.

Encyclopedia of Organizations (Gale Research). The most recent edition of this reference book available at public libraries is the best source for addresses of organizations serving people with chronic illnesses or low-incidence handicaps.

Books

Levert, S. (1995). *When your child has a chronic illness* (Dell Caregiving Guides). Dell Publishing Co.

Lobato, D. (1990). *Brothers, sisters and special needs: Information and activities for helping young siblings of children with chronic illnesses and developmental disabilities.* Paul H. Brookes Publishers.

Perrin, J. , Shayne, M. & Bloom, S. (1992). *Home and community care for chronically ill children.* Oxford University Press.

Tanen-Leff, P. & Walitzer, E. (1992). *Building the healing partnership: Parents, professionals and children with chronic illnesses and disabilities.* Brookline Books.

Handout originally published by NASP, 1992. Resources updated, 1998.

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Communicable Disease in Childhood

A Guide for Parents

Robert G. Harrington
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Background

Sixty percent of the children who go to their doctors with health problems are diagnosed as having some form of infectious communicable disease. What all communicable diseases have in common is that they can be easily "caught" or transmitted from one individual to another. Communicable diseases can take many seriously debilitating and even life-threatening forms such as polio or AIDS, but the "flu," the "common cold" and "sore throat" are the most common. When a communicable disease infects a child attending school, parents must decide whether to stay home with a sick child and skip work or go to work and try to find home care for a sick child. The discomfort and inconvenience of infectious communicable diseases in children can be sharply reduced when parents become involved in disease prevention and control.

General Characteristics of Communicable Disease

There are several reasons why children may be prone to catching diseases when they enter school. First, they may become infected when they engage in contact play, share toys and use other school equipment in common such as desks, toilets and sinks. Second, children's natural immunities are lower than those of adults. Third, the increase in the number of human contacts in school heightens the probability of exposure to infection. Viral or bacterial infections may be spread in several ways: through the water supply, contaminated food, animal waste, the air we breathe, and personal contact with a carrier of the virus.

A feeling of malaise may be the first sign that a child is suffering from an infectious disease and is often followed by listlessness, inability to concentrate, lack of drive, uneasiness, light-headedness, weakness, headache and loss of appetite. Chronic illnesses may adversely affect the child's school performance and self-concept.

Four Broad Types of Communicable Diseases

- ***Respiratory infections*** such as colds and flu are responsible for the greatest number of illnesses. Symptoms include colds, runny nose, coughing and sneezing. These infections become complicated when they lead to ear infections or lower respiratory infections. They are generally transmitted by secretions from the mouth or nose or through droplets coughed or sneezed into the air.

- ***Diarrhea-related infections*** include viral enteritis, giardia, shigella, salmonella and hepatitis A. The infection is transmitted from fecal matter on the hands, food or other objects placed in the mouth.

- ***Skin infections*** may be due to impetigo, lice, scabies, and ringworm and are generally transmitted through direct contact.

- ***Viral rashes*** may result from chicken pox, measles, roseola and mumps, are transmitted through oral and nasal secretions, and many are preventable through immunizations.

Treatment

Medical treatment usually is restricted to symptomatic relief. Fluid therapy may be used to control dehydration and aspirin may be prescribed (except in case of "flu") to relieve aches and to reduce fever. There are few drugs that can be directly used to combat an infecting virus. Viral diseases are resistant to the usual forms of drug therapy now available such as penicillin and the other antibiotics.

Immunization is the most successful control over communicable diseases. Parents should be aware that for the vast majority of children vaccinations are safe, effective and frequently free at their local health clinics. Parents should also keep in mind that immunizations are required for admission to school and schools may bar students from attendance who have not been immunized or who might infect other students.

What Can I Do As A Parent?

- Your child should be seen for medical check-ups on a regular basis.
- Immunization should be current and parents should keep a record to ensure booster shots are timely.
- Don't send your child to school when he/she is sick.
- Report serious illnesses to the classroom teacher and school nurse within 24 hours so that other parents have the opportunity to take action.
- Handwashing after toileting and before handling or eating foods is one of the most effective preventive measures. Liquid soaps are recommended.
- Food preparation areas should be kept clean and dry.
- Cleaning dishes in a dishwasher is more effective than handwashing dishes.
- Diapering areas should be disinfected and diapers properly disposed of.
- Have plenty of tissues, not handkerchiefs, readily available for nose-dripping and dispose of soiled tissues into covered containers.
- To avoid head lice, discourage children from sharing combs, brushes, hats, and other head gear and from hanging coats on top of each other.
- Food containing eggs, mayonnaise, or poultry should be refrigerated to reduce the chance of salmonellosis. Cook poultry well and refuse unpasteurized dairy products.
- Teach your child to cover his or her nose or mouth when he/she coughs or sneezes.
- Avoid dry, overheated rooms which can make respiratory passages more susceptible to infection.
- Wipe off doorknobs, shelves, and other furniture at children's level as well as toys which cannot be placed in the dishwasher at least once a week.
- Encourage children to get plenty of rest and fresh air and drink lots of fluids, especially those rich in Vitamin C.

Recommended Schedule of Immunizations

Age of Child	Diptheria/ Tetanus	Polio	Measles	Mumps	Rubella	Hib
2 months	X	X				
3 months	X					
4 months	X	X				
15 months	X	X	X	X	X	
24 months**						X
4-6 years/(kindergarten entry)	X	X				
14-16 years*	X					

** A booster of Tetanus — needed every 10 years unless there is a "contaminated wound" such as a puncture wound, animal bite or barnyard injury. If it has been more than 5 years since the last TD booster another booster is needed within 72 hours after such an injury.*

*** HIB can be given at 18-23 months for children who are thought to be at increased risk of disease, e.g., children attending day care.*

Resources

For medical questions and immunizations: Contact your child's physician and office staff; nursing staff at your local hospital; local heath department.

Books

Garwood, J. & Bennett, A. (1995). *Your child's symptoms: The parents' diagnostic guide to common childhood ailments with easy reference listings and reassuring advice from a pediatrician.* Berkley Publishing Group.

Keep kids healthy: Cures and remedies for children's illnesses and conditions (1996). Rodele Press.

Kemper, K. (1996). *The holistic pediatrician: A parent's comprehensive guide to safe and effective therapies for the 25 most common childhood ailments.* HarperCollins.

Spock, B. & Rothenberg, M. (1992). *Dr. Spock's Baby and Child Care.* (Also available in Spanish).

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SCHOOL
PSYCHOLOGISTS

Diabetes (Juvenile Diabetes Mellitus)

Information for Parents

by Julianna Marie Ziegler and Paula Sachs Wise, Ph.D.
Western Illinois University

Background

Juvenile Diabetes Mellitus, also called Insulin-Dependent Diabetes Mellitus (IDDM) or Type I Diabetes, affects one out of every 500 to 1000 children. The risk of IDDM is far greater for youngsters than the risk of cystic fibrosis, leukemia, muscular dystrophy and other "better-publicized" diseases. Symptoms of the disease often include frequent urination, increased thirst, rapid weight loss and occasional fatigue, irritability and moodiness. (However, the authors know of at least one case in which the child had no symptoms and the disease was discovered through a routine school physical examination.) The disease is caused by the inadequate production of insulin, a hormone that regulates the metabolism of carbohydrates. In a normally functioning pancreas, insulin is secreted from the beta cells of the Islets of Langerhans (glands located in the pancreas). The insulin regulates the use of glucose and glucose production from carbohydrates, proteins and fats. The glucose is then passed from the blood into the cells to be burned as energy. In a juvenile diabetic, insulin cannot be naturally produced because of the reduction of functioning beta cells. Thus, an individual with IDDM must receive daily injections of insulin throughout life.

The most common periods for the onset of juvenile diabetes are at ages five or six and between the ages of ten and fifteen. Boys and girls are equally likely to become diabetic, while there is a higher rate among Blacks than Caucasians.

Causes: Diabetes is a genetic disorder, but it is not a simple transmittance from the parent to the offspring. For example, siblings of children with IDDM have a much greater risk than the general population of developing the disease, but only about 1 in 50 siblings of diabetics do develop IDDM before the age of 20. Researchers now believe that a defect in the body's immune or defense system may allow diabetes to develop in susceptible children under certain conditions. It is thought that the immune system in the diabetic turns against itself and destroys the beta cells. Another possible cause of the disease is thought to be a viral infection that damages the beta cells or triggers an auto-immune response, which in turn causes beta cell destruction. Whatever the cause, the beta cells are destroyed beyond recovery.

Development

Daily insulin injections do control the disease satisfactorily. While such insulin therapy allows for a lengthened life span for the diabetic (i.e., longer than the diabetic would face without insulin injections), the expected lifespan of the diabetic is still shorter than that of the nondiabetic. Over the lifespan, diabetics, particularly those who are "poorly controlled" (e.g., careless about insulin injections and/or dietary restrictions), may develop complications that affect the eyes, kidneys, nervous system and/or cardiovascular system. Blindness and kidney failure often occur ten to twenty years after the initial diagnosis in poorly controlled diabetics.

The two most common short-term complications are *Hypoglycemia* (low blood sugar) and *Hyperglycemia* (high blood sugar). These complications may be caused by unintended changes in one's treatment (e.g., taking an insulin injection late; skipping or delaying a meal); by errors in disease management (e.g., misjudging the amount of insulin needed; eating too little before exercising); or the complication may be difficult to explain.

Hypoglycemia impairs thinking and motor skills and can cause symptoms such as extreme weakness, dizziness, fatigue, sweating, irritability, headache, anxiety and shakiness. Loss of consciousness (and occasionally death) can occur if the insulin reaction is not treated promptly with a source of sugar. Often the symptoms of hypoglycemia resemble drunkenness because the individual may exhibit unruly behavior or seem lethargic or unresponsive.

Symptoms of ***hyperglycemia*** include short-term effects such as tiredness, increased thirst and dry mouth, headache, flushing, frequent urination and nausea. If hyperglycemia is allowed to continue for several hours or several days, results can include coma or death. Many of the long-term effects attributed to diabetes may actually be the result of poorly monitored chronic hyperglycemia over a long period of time.

What Can I Do as a Parent

Probably the major challenges facing parents of a diabetic child are to be informed about the disease, to oversee proper medical and diet management, to be alert to changes in the child's health, and to communicate the child's needs to school personnel. In light of the short-term and long-term life-threatening complications of IDDM, it is vital that juvenile diabetics adhere to major life style adjustments from the moment of diagnosis. Extensive education regarding the disease and its treatment are essential for the diabetic patient and for key people in the patient's environment (e.g., family members, friends, teachers and other school personnel). From the time of the diagnosis, parents need to have good communication with the primary physician and medical team. Ideally, a parent-teacher conference at the beginning of the year can provide a forum for the exchange of information about the child's medical history and treatment needs.

The daily routines of blood sugar testing, insulin injections and meticulous monitoring of diet are tedious, complicated and time-consuming. Attitudes of patients may change with age and vary from individual to individual. Some children feel depressed and withdraw from normal social contacts. Other young patients feel anger and resentment as illustrated in their attitudes toward management. Still others react with self-pity and insecurity. Many diabetic teenagers report concerns about future roles, such as vocational choices, marriage, childbearing, future complications and early mortality from long term diabetes.

Impact on child and family: Once diagnosed, it is essential that parents provide the diabetic child with information about the disease and its treatment that is readily understood. The degree of detail and the nature of the explanations will naturally be different for very young children compared to older children and adolescents. In some cases, the child will know that he or she is "sick" because of the symptoms, while in other cases the child might not yet be aware that anything is really wrong, and may be upset by the medical procedures used to confirm the diagnosis. It is most important that the child understands that this illness and its treatment are not punishment for bad behavior. It is also critically important that children of all ages understand the need to carefully and faithfully follow prescribed treatment with insulin and diet.

Impact on school adjustment: Managing a child's diabetes in school is a complicated task for the child, for the parents and for school personnel. It is not unusual for diabetes to interfere with the child's school performance and peer relationships. In the preschool and elementary years, parents and school personnel are concerned most with issues of physical safety and adherence to the diabetic regimen. The children themselves may focus upon their perceptions that they are being treated differently and unfairly at birthday parties, school treat days and so forth. Some children either do not want their friends to know that they are diabetic or they lack the social skills to talk to their friends about the illness. Diabetic youngsters may avoid their peers or become angry and aggressive when teased about the disease. Understanding the medical as well as the emotional aspects of diabetes will assist parents and teachers in helping the diabetic child adjust to the classroom and the illness.

Resources

Court, S. & Lamb, B. (Eds.). (1997). *Childhood and adolescent diabetes (practical diabetes).* John Wiley & Sons.

Pirner, C. (1991). *Even little kids get diabetes.* Albert Whitman & Co. (for ages 4-8)

Wysocki, T. (1997). *The ten keys to helping your child grow up with diabetes: A practical guide for parents and caregivers.* American Diabetes Association.

Internet sites:

CDC-Diabetes Home Page:
<http://www.cdc.gov/nccdphp/ddt/ddthome.htm>

Children with Diabetes:
<http://www.childrenwithdiabetes.com/>

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Two peak periods for the onset of IDDM have been identified — the first at ages five or six and the second between the ages of ten and fifteen. Boys and girls are affected in equal numbers, while the incidence is 1.5 times higher for Whites than for Blacks.

Causes: It is clear that the susceptibility to diabetes is inherited. It is not a simple transmittance from the parent to the offspring, however. For example, siblings of children with IDDM have a much greater risk than the general population of developing the disease, but only about 1 in 50 siblings of diabetics develop IDDM before the age of 20. Researchers now believe that a defect in the body's immune or defense system may allow diabetes to develop in susceptible children under certain conditions. It is thought that the immune system in the diabetic turns against itself and destroys the beta cells. Another possible cause of the disease is thought to be a viral infection that damages the beta cells or triggers an autoimmune response, which in turn causes beta cell destruction. Whatever the cause, the beta cells are destroyed beyond recovery.

Development

Daily insulin injections do control the disease satisfactorily. While such insulin therapy allows for a lengthened life span for the diabetic (i.e., longer than the diabetic would face without insulin injections), the lifespan of the diabetic is still shorter than that of the nondiabetic. Over the lifespan, diabetics, particularly those who are "poorly controlled" (e.g., careless about insulin injections and/or dietary restrictions), may develop complications that affect the eyes, kidneys, nervous system and/or cardiovascular system. Blindness and kidney failure are commonly seen about ten to twenty years after the initial diagnosis in poorly controlled diabetics.

The two most common short-term complications are Hypoglycemia (low blood sugar) and Hyperglycemia (high blood sugar). These complications may be caused by deviations in one's treatment (e.g., taking an insulin injection late; skipping or delaying a meal); by errors in disease management (e.g., misjudging the amount of insulin needed; eating too little before exercising); or the complication may be difficult to explain.

Hypoglycemia impairs cognitive and motor functioning and can cause symptoms such as extreme weakness, dizziness, fatigue, sweating, irritability, headache, anxiety and shakiness. Loss of consciousness (and occasionally death) can occur if the insulin reaction is not treated promptly with a source of sugar. Often the symptoms of hypoglycemia resemble drunkenness because the individual may exhibit unruly behavior or seem lethargic or unresponsive.

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What Can I do as a Teacher

Probably the major challenges facing the teacher of a diabetic child are to be informed about the disease and to be alert to changes in the child's health. In light of the short-term and long-term life-threatening complications of IDDM, it is vital that juvenile diabetics adhere to major life style adjustments from the moment of diagnosis. Extensive education regarding the disease and its treatment are essential for the diabetic patient and for key people in the patient's environment (e.g., family members, friends, teachers and other school personnel). Ideally a parent-teacher conference at the beginning of the year can provide a forum for the exchange of information about the child's medical history and treatment needs.

The daily routines of blood sugar testing, insulin injections and meticulous monitoring of diet are tedious, complicated and time consuming. Attitudes of patients may change with age and vary from individual to individual. Some children feel depressed and withdraw from normal social contacts. Other young patients feel anger and resentment as illustrated in their attitudes toward management. Still others react with self-pity and insecurity. Many diabetic teenagers report concerns about future roles, such as vocational choices, marriage, childbearing, future complications and early mortality from long term diabetes.

Managing a child's diabetes in school is a complicated task for the child, for the parents and for school personnel. It is not unusual for diabetes to interfere with the child's school performance and peer relationships. In the preschool and elementary years, parents and school personnel are concerned most with issues of physical safety and adherence to the diabetic regimen. The children themselves may focus upon their perceptions that they are being treated differently and unfairly at birthday parties, school treat days and so forth. Some children either do not want their friends to know that they are diabetic or they lack the social skills to talk to their friends about the illness. Diabetic youngsters may avoid their peers or become angry and aggressive when teased about the disease. The classroom teacher can assume an important role in the life of the diabetic child, supplementing the role of parents and physicians. Understanding the medical as well as the emotional aspects of diabetes will assist teachers in helping the diabetic child adjust to the classroom and the illness.

Resources

Court, S. & Lamb, B. (Eds.). (1997). *Childhood and adolescent diabetes (practical diabetes).* John Wiley & Sons.

Lyen, K.R. (1984). Juvenile diabetes. In J. Fithian (Ed.), *Understanding the child with a chronic illness in the classroom* (pp. 1-13). Phoenix: Oryx.

Pirner, C. (1991). *Even little kids get diabetes.* Albert Whitman & Co. (for ages 4-8)

Wysocki, T. (1997). *The ten keys to helping your child grow up with diabetes: A practical guide for parents and caregivers.* American Diabetes Association.

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Drug Abuse in Children and Adolescents

Information for Parents

by Deanie Campbell
Camilla, GA

Background

During the 1990's, the use of drugs by adolescents has shown a significant increase, including use of cigarettes, alcohol, marijuana, inhalants, cocaine and LSD. Not only are adolescents using drugs, but many children begin to experiment with/use drugs prior to age thirteen.

There are many reasons for drug use among children and adolescents: drugs in the home (e.g., cigarettes, alcohol, etc.); lack of or lax adult supervision (e.g., parents seldom at home); availability of drugs (e.g., easy access to drugs in the community or at school); peer pressure; divorce (which contributes to less adult supervision); curiosity; change in perception (such that children have no fear or very little fear of the risks of drug use); media influence (television, music); escapism (to get away from pressures); lack of opportunity to participate in alternative activities (e.g., involvement in school activities, clubs, sports).

Regardless of the reasons, there are significant risks for the children who use drugs. Commonly associated risks include: damage to the body (e.g. the brain, heart, lungs and immune system), impairment of judgement, impaired ability to learn, impaired memory and perception, depressed motor ability, decline in academic performance, accidents and increased tendency toward suicide or violence.

Prevention

Drug abuse, as with most problems, is easier to prevent than to remediate. There are several steps which can be taken in order to provide a foundation for the prevention of or resistance to drug use/abuse.

Respect and trust: The first and foremost step to take is to develop a sense of respect and trust between yourself and the child (and the earlier, the better). In order to do this, you will have to be involved with him/her, spending time in activities together and showing that you enjoy being with him/her and recognize his/her likes/dislikes and interests.

Listen! Also important is to listen, not just talk to or with the child, but listen to what he/she has to say. Don't interrupt. Don't assume that you understand what he/she means; ask questions or state what you think is meant and verify that you understood correctly. This shows that you did listen, that what the child says is important to you, and that you *care* whether you understand what he/she means. (This is more than an "Uh-huh" as you read the paper, address envelopes, etc.) And, listening and understanding involves objectivity — not judgement; try to understand what the child is saying without judging his/her motives, opinions or conclusions. Even when your words are objective, watch the body language — rolling your eyes at a certain friend's name, crossing your arms and looking down at the child, placing your hands on your hips with your legs akimbo — these are all body language that shouts, "Here comes the judge!"

Acknowledge feelings: While you're listening to the child, it is important to let him/her know that you care not only about what he/she thinks, but also about what he/she *feels.* It is important that all human beings have a sense that someone cares about their feelings. It is also important that he/she learn to recognize and express his/her feelings. The inability to express feelings is an identifiable characteristic of individuals who use and abuse drugs. Listening and talking with your children and sharing at times your own feelings teaches them that it is okay to have and to express feelings. But you must take care not to trivialize their feelings. What may seem of little concern in the long run may seem a dire calamity to your child at the moment.

Teach about choices and consequences: Above all, teach the child the inevitable — for every choice, there is a consequence. Teach the child that a choice is followed by some response; such as choosing to pull the cat's tail may end with a scratch (for young children) or choosing to drive over the speed limit may end with a ticket and a fine. But beyond this, teach him/her to evaluate the consequence *before* making the choice. Consider what may happen first and then decide if it's worth the cost. For instance, choosing not to "huff" along with everyone else may result in being an outcast in front of peers; likewise, choosing to huff may result in brain damage and/or death. It doesn't seem worth it to huff — the cost is too great.

Encourage activities to build self-esteem and belonging: Encourage and help him/her become involved in leisure/extracurricular activities which provide a sense of accomplishment and belonging. (It is even more advantageous if these activities also provide extra supervision which may be lacking at certain points in the day.) These activities might include: recreational activities through school or civic organizations, volunteer activities at local hospitals or schools, scouting organizations, church groups, musical/fine arts activities, orienteering, etc.

Specifically talk with children about drugs. What do they know? How would they react if someone offered drugs or tried to persuade them to use? Listen to the answers. They may know more than you about drugs. On the other hand, they may know very little and may need to be told of the risks and consequences of drug use/abuse. Sharing information about drugs/drug abuse should be developmentally appropriate to the child. Small children can be told it is very dangerous and that they can get very sick or die if they use drugs except when they are sick. Small children can learn to "Just Say No!" Older children, approximately ten or eleven and older, need to be instructed in the dangers — physical, mental, and judicial.

If Your Child Needs Help

Characteristics and warning signs: If you suspect your child of drug use/abuse, first consider common characteristics of children and adolescents who use drugs: instability in the home; lack of religious affiliation; use of drugs by other family members; shyness; delinquent/antisocial behavior; impulsivity; inability to deal with problems; poor academic performance; low self-esteem; difficulty expressing feelings; and association with peers who use drugs.

Specific warning signs of drug use include: truancy, skipping classes, decline in grades in school, change of friends, withdrawal from activities which were formerly important to the child, difficulties with the law, lying, stealing or borrowing money, change in dress (such as wearing long sleeves to hide need marks), stealing and possession of fake identification and/or drug paraphernalia. Physical symptoms may also be present, including slurred or unintelligible speech, lapses of memory, changes in appetite/eating habits (e.g., increase/decrease), headache, nausea and/or vomiting, impairment in motor skills, bloodshot eyes and dry mouth, dilated pupils, insomnia, coughing, nosebleeds, congested or runny nose, hallucinations, exhaustion and/or fatigue, blurred/double vision, confusion, aggressiveness, depression, erratic sleep patterns, and talkativeness.

If you believe drug use/abuse is possible or probable, you should talk with the child — who may utterly deny any drug use or who may confess and ask for help or who may confess an experimentation with drugs which has occurred but is now over. You can also talk with siblings or close friends whom you know do not use drugs and see if they have concerns for him/her. You can contact your school psychologist, social worker, counselor or chemical dependency specialist. Most school districts have professionals who can conduct a screening and help identify the need for referral for evaluation and treatment. Many treatment centers and some counselors in private practice will complete the initial assessment without charge and offer advice or referrals as necessary.

Other sources of help: Drug use/abuse is prevalent and there are many agencies which offer assistance. Local libraries, schools, health departments, mental health programs and other agencies are able to offer information. Any treatment facilities in your area can offer information and referrals.

Resources

Cohen, P. (1991). *Helping your chemically dependent teenager recover. A guide for parents and other concerned adults.* Minneapolis: The Johnson Institute.

Levant, G. (1998). *Keeping kids drug free: D.A.R.E. official parents' guide.* Thunder Bay Press.

Martin, M. & Waltman-Greenwood, C. (1995). *Solve your child's school-related problems.* New York: HarperPerenniel.

Milhorn, T. (1994). *Drugs and alcohol abuse: The authoritative guide for parents, teachers and counselors.* Plenum Press.

National Institute on Drug Abuse. "Facts About Teenagers and Drug Abuse." Call (800)662-4357.

Shulman, J. (1991). *The Drug-Alert Dictionary and Resource Guide.* Frederick, MD: Twenty-First Century Books.

Websites

National Institute on Drug Abuse (NIDA):
<http://www.nida.nih.gov/> (fact sheets, online publications, teaching resources)

Substance Abuse and Mental Health Services Administration (SAMHSA):
<http://www. Samhsa.gov/> (publications, reports)

Adolescent drug and alcohol abuse:
<http://www.addictions.net/adoles.htm>

Organization

National Institute on Drug Abuse: hotline at 1-800-662-4357 or contact: NIDA Information & Treatment Center Social Scientific Systems, Inc., 12280 Wilkens Avenue, I 1st Floor, Rockville, MD 20852.

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Eating Disorders in Adolescence

Information for Parents and Teachers

**by Geral Blanchard, Sheridan, Wyoming,
Sean O'Halloran, Ph.D., University of Northern Colorado,
and Andrea Canter, Ph.D., Minneapolis Public Schools**

Overview

Eating disorders are characterized by an all-consuming desire to be thin, a desire that is unrealistic and threatens an individual's physical and emotional health. Fear of weight gain is exhibited through cycles of self-starvation and/or cycles of binge eating/purging. In *anorexia nervosa,* the individual's weight has fallen more than 15% below normal and, with females, menstruation (once it has occurred) has not occurred in over three months. *Bulimia* is much more common than anorexia. It involves an abnormal and continuous craving for food followed by self-induced vomiting, laxative or diuretic abuse, compulsive exercise, and/or strict dieting, with binging and purging episodes occurring at least twice per week and typically, feelings of loss of control.

Bulimia, although 2 or 3 times more common than anorexia, wasn't recognized as a distinct disorder until 1976. Prior to that time, most persons with this disorder had been labeled anorexic. Nearly half of diagnosed anorexics can be suffering from bulimia. The reverse is also true. Both are learned behaviors that can be unlearned. Both are, in part, disorders of our culture, reflecting the emphasis on "thin" as the ideal body type, particularly for girls and women. Eating disorders typically occur during adolescence when youth are most concerned about appearance and acceptance and most susceptible to the influences of peers and the media.

It is estimated that about 1% of the population will be diagnosed with anorexia, and about 4% with bulimia (following strict diagnostic criteria). Additionally, many adolescents, particularly girls, exhibit many characteristics of eating disorders (chronic dieting, preoccupation with weight, abuse of diet pills, excessive exercising) without meeting criteria for a "disorder." Of the population with an eating disorder, 90%-96% are female.

Causes of Eating Disorders

Generally, researchers have concluded that exposure to the socio-cultural emphasis on thinness interacts with the influences of media, self concept, family and peers in predisposing individuals to psychological stress resulting in eating disorders. Among adolescent girls, eating disorders can be a reaction to the approaching demands of adult sexuality and independence as well as a response to cultural pressures and media influences to have a perfect body. Compulsive fasting provides a sense of control over one's self and others. Strict self-imposed rules about food substitute for genuine independence. Among adolescent boys, those who develop eating disorders are often athletes whose sport demands weight control (e.g., wrestling). They lack a sense of independence, identity and control over their lives. These young men seem to feel like an extension of others and do things to please others.

Victims of physical and sexual abuse also appear to be at-risk for developing eating disorders, as it can often lead to distorted body image and fear of developing sexuality.

Self concept: Adolescents who particularly feel a lack of personal and social control appear at significant risk for developing eating disorders. Research among girls has found that those who develop eating disorders typically have low self-esteem in the areas of personal, social and academic competence, and physical self concept.

Body dissatisfaction has been identified as the most significant predictor of eating disorders. Particularly as they reach adolescence, many girls compare their changing bodies to society's idealized female model and experience increasing degrees of dissatisfaction. The degree of dissatisfaction does not appear to be related to actual weight, but to the subjective opinion of weight — that is, while many girls believe that they are overweight, this is not consistent with their actual weight.

Chronic dieting: Although common among teenagers, what may at first appear to be benign dieting can grow into a full-blown eating disorder. Stringent denial of food can give way to a binge of eating "forbidden" foods, followed by guilt and even more stringent diets and exercise routines. Normally, individuals follow dieting periods with a return to moderate eating, while disordered dieters tend to either binge (bulimia) or refuse to eat at all (anorexia).

Warning Signs

Parents and teachers should be alert to any of the following symptoms of a possible eating disorder:

- Frequent complaints about current weight
- Obsessive concern about size, shape of body parts (stomach, hips, thighs, buttocks)
- Preoccupation with thinness
- Excessive fear of gaining weight
- Chronic, excessive dieting
- Excessive exercising
- Purchase and use of diet pills, laxatives, diuretics
- Evidence of self-induced vomiting
- Binge eating
- Fussiness about food ("picky eater")
- Lack of interest or obsessive interest in food

Treatment

It is essential to identify and break the pattern of eating disorder due to the dire physical consequences. Severe weight loss and malnutrition during physical maturation can result in delayed puberty, stunted growth, risk of future bone loss (osteoporosis) and difficulties related to hormonal and other chemical imbalances. In its most severe form, an eating disorder can be fatal due to cardiac problems, electrolyte imbalance or suicide. Treatment should address immediate health threats as well as prevention and wellness. The prognosis for recovery is best when eating disorders are diagnosed and treated early.

Medical attention is a necessary component in treating all eating disorders as starving, binging, and purging can take a terrible toll on the body. Drug treatment is sometimes used to augment individual and group therapy.

Psychotherapy will help persons with eating disorders to develop a mature dependence on another person, rather than on inanimate objects like food, as a way to regulate emotions. Challenging distorted body images can occur once a secure therapeutic relationship is in place. Traumatic childhood experiences (e.g., abuse) also need to be explored while the victim is empowered, reclaims competence and develops the capacity for self-soothing without food or chemicals. Involvement of the whole family is often necessary to address the patient's focus on food and any family issues contributing to dysfunction, to provide ongoing support, and to monitor eating behavior.

Behavioral and cognitive-behavioral strategies are used in treating individuals with eating disorders in order to immediately reduce dangerous behaviors and ultimately to gain self control over eating habits and to change self perceptions.

What Can Parents Do?

- Educate yourself about eating disorders, including symptoms, causes and treatment options.
- Be aware of your own body image and eating habits. Be ready to address your own problems with body image and dieting in order to provide a more healthy model for your children.
- Avoid focusing on calories, weight, dieting and exercise as family "topics."
- Help your children combat societal pressure. Discuss "reality" vs the images presented by the media.
- Provide an environment that encourages individuality, independence and feelings of competence with unconditional love and support.
- Avoid being judgmental. Be reliably available and remember not to try to control your child's disorder.
- Encourage physical competence by focusing on positive physical attributes and skills, and support your child's efforts to improve physical fitness and strength.

What Can Teachers Do?

- Be aware of the symptoms, causes and general treatment of eating disorders. Be alert to warning signs and notify parent of any concerns.
- Consult with your school psychologist, school nurse, social worker, etc. if you notice any warning signs or have concerns about a student's weight or eating habits.
- Educational approaches should not focus exclusively on teaching good nutrition or proper eating habits. Discuss the cultural pressures and media influences to have a perfect body, societal pressures to be sexual, the impact of abuse, co-dependency, etc.
- Be ready for a disclosure of physical and/or sexual abuse. Don't overreact. Report this information to the proper child protection authorities and consult with student support personnel at school.
- Be prepared to provide steady, non-demanding support throughout the student's treatment.

What Can Schools Do?

- Promote wellness and fitness among all students through health education and sexuality education.
- Increase student and parent awareness of appropriate weight maintenance and modification programs, through health education classes, PTA presentations, etc.
- Provide support programs to help students develop constructive coping strategies and enhanced self esteem.
- Establish systems to refer and support at-risk students.
- Be alert to use of media and practices that emphasize unrealistic images and messages related to physical attributes; monitor weight-loss practices among athletes (particularly gymnasts and wrestlers).
- Educate school personnel about eating disorders, prevention and intervention.

Resources

Organizations

National Association of Anorexia Nervosa and Associated Disorders, P.O. Box 7, Highland Park, IL 60035, (312) 831-3438

National Institute of Mental Health Eating Disorders Program, Bldg. 10, Room 3S 231, Bethesda, MD 20892, (301) 496-1891

Books

Anderson A. (Ed.). (1990). *Males with eating disorders.* New York: Brunner/Mazel.

Costin, C. (1996). *The eating disorder sourcebook.* Lowell House.

*Dolan, B. & Gitzinger, I. (1994). *Why women? Gender issues and eating disorders.* London: Athlone Publishing.

Fairburn, C. (1995). *Overcoming binge eating.* New York: Guilford Publications.

Lemberg, R. (Ed). (1992). *Controlling eating disorders with facts, advice and resources.* Phoenix: Oryx Press.

Meadow, R. & Weiss, L. (1992). *Women's conflicts about eating and sexuality.* New York: Haworth Press.

*O'Halloran, M.S. (1993). *Focus on eating disorders.* Denver: ABC-CLIO.

Phelps, L., Augustyniak, K., Nelson, L. & Nathanson, D. (1997). Adolescent eating disorders, chronic dieting and body dissatisfaction. In Bear, G., Minke, K. & Thomas, A. (Eds.), *Children's Needs II* (pp. 909- 915). Bethesda, MD: National Association of School Psychologists.

*Pipher, M.B. (1995). *Hunger pains: From fad diets to eating disorders — what every woman needs to know about food, dieting and self-esteem.* Hollbrook, MA: Adams Publishing.

Siegel, M., Brisman, B. & Weinshel, M. (1997). *Surviving an eating disorder: New perspectives and strategies for families and friends.* New York: HarperCollins.

* Recommended reading for older adolescents

Internet Sites

Anorexia Nervosa and Related Eating Disorders, Inc.:
<http//www.anred.com/>

Center for Eating Disorders (St. Joseph Medical Center, Towson, MD):
<http//www/eating-disorders.com/>

Healthtouch Online:
<http//www.healthtouch.com> (link to health related topics)

National Eating Disorders Organization (NEDO):
<http//www.laureate.com/nedointro.html> (Home page with links to various resources)

Some material is adapted from the chapter by Phelps et.al in Children's Needs II *(see resources above).*

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HIV/AIDS

What Parents Should Know

by Tiffany A. Chenneville & Howard M. Knoff, Ph.D.
University of South Florida

Introduction

Acquired Immune Deficiency Syndrome (AIDS) is not only a health crisis, but a social crisis that has affected every sector of the United States. The number of persons with AIDS in the United States is staggering, and it continues to multiply. Furthermore, the growing number of individuals infected with the Human Immunodeficiency Virus (HIV), the virus that causes AIDS, is even more disturbing. Nobody is immune because AIDS does not discriminate by sexual orientation, gender, race, socioeconomic status or age.

The failure of AIDS to discriminate by age is evident by the growing number of children and adolescents infected by HIV/AIDS. There also are scores of children who are not infected, yet are affected by HIV/AIDS because one or both of their parents, or other family members, have been diagnosed as being HIV positive or having AIDS. In fact, an increasingly large number of children have been orphaned by parents who have died from AIDS. It is estimated that over 80,000 children will have been orphaned by the year 2000 due to parental deaths caused by AIDS. Non-infected children and adolescents also may be affected through their association with peers or significant others who are HIV positive, have AIDS, or who have lost loved ones due to AIDS.

HIV/AIDS in Children and Young Adults

As of June, 1996, over a half a million (548,102) diagnosed AIDS cases had been reported to the Centers for Disease Control. Approximately 1.3% (or 7,296) were children less than thirteen years old. This is a significant increase from the 3,898 pediatric AIDS cases reported just three years before in 1992. Relative to adolescents, the incidence of AIDS also is considered to be large and increasing. In fact, AIDS is considered to be one of the leading causes of death among teenagers, and it is estimated that two individuals under the age of 25 are infected with HIV every hour. AIDS is also the leading cause of death for people between the ages of 25 to 44 in the United States. This is significant because it is believed that many of the young adults currently infected with HIV/AIDS may have contracted the HIV virus during adolescence. Thus, adolescent incidence figures may underestimate those who contract HIV but do not exhibit its symptoms until early adulthood.

Relative to gender, HIV is being contracted more rapidly by women, including young girls and adolescents, than by men. Critically, the large and increasing number of females with AIDS also increases the probability of children being born with HIV due to pre-natal or peri-natal transmission. It is estimated that 25% of infants born to HIV-infected mothers will themselves become infected. These children represent one of the fastest growing groups testing positive for the HIV virus.

Definitions

- *HIV* — Human Immunodeficiency Virus, the virus that causes AIDS.
- *AIDS* — Acquired Immunodeficiency Syndrome, the condition that results from HIV infection. AIDS is distinguished from HIV by the presence of an opportunistic infection or a T-cell count of 200 or less.

What We Know About HIV/AIDS

Transmission

HIV is transmitted through blood, semen, vaginal fluid, and in some cases, breast milk. This allows for many possible modes of transmission including the following:

- Sexual contact (vaginal, anal, oral) with an HIV-infected person
- Sharing needles or syringes with someone who is HIV positive
- Mother to child transmission during pregnancy, during delivery, or in some cases, through breast feeding
- Blood transfusion with contaminated blood products, although the risk of HIV transmission through blood transfusions is minimal given current blood screening practices employed by blood banks.

It is critical to note that HIV is not transmitted through casual contact.

Prevention

- Abstinence from sexual activity
- Condom use during sexual activity (vaginal, anal, and oral)
- Not sharing needles or syringes

It is critical to note that condoms are not 100% effective but greatly reduce the risk of HIV transmission.

Facts about AIDS

- You cannot tell if someone has AIDS by looking at them.
- Currently, there is no cure for AIDS.
- Currently, there is no immunization to guard against the transmission of HIV.
- AIDS affects people of all ages, races, and socioeconomic status, and individuals with different sexual orientations including heterosexuals, bisexuals, and homosexuals.
- No cases of AIDS have been reported due to kissing, biting, or mosquito bites.
- HIV is not transmitted through touching or hugging.
- HIV cannot be contracted from donating blood.
- There are no reported cases of HIV being transmitted from child to child or child to staff member in a school building due to fights or contact sports.

Impact of HIV/AIDS on Children and Adolescents

Many issues relative to academic and social development and functioning arise for children and adolescents with HIV or AIDS. In addition to the physical implications of HIV/AIDS, there are various neurological and psychosocial implications as discussed below.

Physical Implications

HIV infection suppresses the immune system making persons testing positive for HIV vulnerable to opportunistic infections and illnesses which include, but are not limited to, certain forms of cancer, pneumonia, and fungal infections. Therefore, the physical symptoms experienced by persons with HIV or AIDS will vary according to their physical condition and the impact of these illnesses. HIV-infected individuals who have not been diagnosed with an opportunistic infection may also experience generalized symptoms associated with immune suppression such as fatigue, diarrhea, weight loss, fever, and night sweats. To date, there is no cure for AIDS; however, pharmacological therapy (e.g., antiretroviral medications, protease inhibitors) is used to prolong the onset of symptoms.

Neurological Implications

Antiretroviral medications, as well as medications which help to prevent serious opportunistic infections, are thought to be partially responsible for extending the life of HIV-infected individuals.

However, the quality of life for such individuals can be negatively affected by subtle, progressive and insidious problems directly resulting from HIV infection, including neurological impairment. HIV infection and AIDS not only impact the immune system, but also the central nervous system. In fact, it is hypothesized that HIV may directly infect the brain. As such, neurological impairment may result from either a direct attack on the central nervous system or through opportunistic infections that the body cannot stop due to HIV or AIDS.

Many children infected with HIV experience some degree of difficulty resulting from developmental delays and/or cognitive disabilities. It is known that HIV infection can interfere with the normal brain development of children, resulting in neurological damage. This is especially true for children infected during and shortly after birth, whose central nervous systems are not yet fully developed at the time of infection. Among other types of brain damage, visual and auditory short-term memory loss, attention deficits, language disorders, spatial ability problems and language difficulties may be observed in children with AIDS. Furthermore, moderate to severe mental retardation is associated with certain neurological disorders caused by HIV.

While HIV-related neurological impairment in children is commonly associated with cognitive delays, neurological impairment in adolescents is more commonly associated with cognitive deterioration. Neurological damage commonly results in the death of children with AIDS.

Social Implications

Many of the symptoms reported by children with AIDS are similar to those experienced by children living with other chronic illnesses. Such symptoms include loss of abilities, physical impairments and the fear of impending death. Each of these may result in psychological reactions, including anxiety and depression. However, the social experiences of HIV-infected children differ from those of children with other chronic illnesses in several ways. First, many HIV-infected children, especially those who contract the virus perinatally, may have to cope with losses associated with AIDS-related illnesses and deaths within their families. Second, HIV-infected children are likely to experience additional risk factors: chronic poverty, housing problems, nutritional problems, poor access to medical and social support services, and exposure to violent or dangerous neighborhood environments. Third, and most important, is the stigma associated with HIV/AIDS. AIDS-related stigma is the result of both fear and discrimination. Attempts have been made to deny rights to individuals infected with HIV/AIDS, including the right to employment and the right to a free and appropriate education. Although federal and legal mandates attempt to protect the constitutional rights of people with AIDS, stigmatization and discrimination persist.

What Can I Do as a Parent?

- Pregnant mothers who are not known to be HIV positive but have engaged in high-risk behaviors that increase the likelihood of HIV transmission should be tested for the virus so that precautions can be taken to reduce the risk of transmission to the unborn child, if needed.
- Pregnant mothers who are known to be HIV positive should share this information with their physician so that precautions can be taken to reduce the risk of transmission to the unborn child. Antiretroviral medication taken by pregnant mothers has been shown to reduce the rate of mother-to-child transmission during pregnancy or delivery from 25% (without medication) to 8% (with medication).
- It is a well-documented fact that children model their parents' behavior. Therefore, it is important that parents model appropriate behavior that emphasizes problem solving and informed decision-making. It also is critical that parents model behavior that discourages discrimination and prejudice against persons with HIV/AIDS. This type of modeling by parents not only impacts their own children, but also the communities in which they live.
- Parents have a responsibility to educate themselves and their children about HIV/AIDS in an attempt to prevent the spread of this deadly disease. Parents must be knowledgeable about the modes of

transmission and the modes of prevention if they are to educate their children about how to protect themselves. AIDS education policies relative to what can and cannot be taught vary among schools. Therefore, parents cannot rely solely on their school systems to provide accurate information to their children about how to prevent contracting HIV. Parents can educate themselves by taking courses offered by the American Red Cross (see the Resource section below for an 800 number) or other local community agencies.

- Parents should be aware of the relationship between alcohol/drug use and HIV/AIDS. Alcohol and drug use are considered risk factors for the transmission of HIV because: (a) it is a known fact that alcohol and drugs decrease inhibition, thus increasing the likelihood that individuals will engage in high risk behavior such as unprotected sex; and (b) intravenous drug use is known to be a high risk behavior that may result in HIV transmission. There are also many other negative consequences of alcohol/drug use not associated with HIV/AIDS. Therefore, it is important that parents educate their children about risks associated with alcohol/drug use and attempt to promote abstinence from such substances.
- Do not be fearful if your child is in a classroom with a child who is HIV infected or who has AIDS. Remember that there are no documented cases of AIDS transmission due to casual contact, biting, fighting or contact sports.
- Universal precautions should be maintained when coming into contact with blood or other bodily fluids that may contain blood. Universal precautions refer to the use of gloves and disinfectants when in contact with blood or blood-contaminated products.
- Remember that HIV cannot be transmitted through personal contact such as hugging and kissing. It is critical that loving and affectionate contact be maintained with a child with HIV/AIDS.

Resources

Centers for Disease Control National AIDS Hotline:
800-342-AIDS (English)
800-344-SIDA (Spanish)
800-243-7889 (TTY/TDD)

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AIDS Action Council, 2033 M Street NW, Suite 802, Washington, DC 20036; (202) 293-2886

American Institute for Teen AIDS Prevention, P.O. Box 136116, Ft. Worth, TX 76136; (817) 237-0230

American Red Cross, HIV/AIDS Education Office, 1709 New York Avenue NW, Suite 208,
Washington, DC 20006; (202) 434-4077

National Coalition for Advocates for Students, 100 Boylston Street, Suite 737, Boston, MA 02116;
(617) 357-8507

National Gay and Lesbian Task Force, 1734 14th Street NW, Washington, DC 20009; (202) 332-6483

National Gay Rights Advocates, 540 Castro Street, San Francisco, CA 94114; (415) 863-3624

Planned Parenthood Federation of America, 810 Seventh Avenue, 14th Floor, New York, NY 10019; (212) 541-7800

Sex Information and Education Council of the United States (SIECUS), 130 West 42nd Street, 25th Floor, New York, NY 10036; (212) 819-9770

Journal of the American Medical Association HIV website: *<http://www.ama-assn.org/special/HIV/hivhome.htm>*

Books for Children and Teens

Christie-Dever, B. & M. Ramsey (1996). *AIDS: Answers to questions kids ask.* Learning Works. (Age 9-12)

Christie-Dever, B. & M. Ramsey (1996). *AIDS: What teens need to know.* Learning Works.

Hyde, M.O. (1994). *Know about AIDS* (revised). Walker & Co.

Hyde, M.O. (1995). *AIDS: What does it mean*? (5th edition). Walker & Co.

Jussim, D. (1997). *AIDS and HIV: Risky business (teen issues).* Enslow Publishers.

Silverstein & Silverstein (1989). *Learning about AIDS.* Enslow Publishing.

NATIONAL
ASSOCIATION OF
SCHOOL
PSYCHOLOGISTS

HIV/AIDS

What Educators Should Know

**by Tiffany A. Chenneville & Howard M. Knoff, Ph.D.
University of South Florida**

Introduction

Acquired Immune Deficiency Syndrome (AIDS) is not only a health crisis, but a social crisis that has affected every sector of the United States. The number of persons with AIDS in the United States is staggering, and it continues to multiply. Furthermore, the growing number of individuals infected with the Human Immunodeficiency Virus (HIV), the virus that causes AIDS, is even more disturbing. Nobody is immune because AIDS does not discriminate by sexual orientation, gender, race, socioeconomic status or age.

The failure of AIDS to discriminate by age is evident by the growing number of children and adolescents infected by HIV/AIDS. There also are scores of children who are not infected, yet are affected by HIV/AIDS because one or both of their parents, or other family members, have been diagnosed as being HIV positive or having AIDS. In fact, an increasingly large number of children have been orphaned by parents who have died from AIDS. It is estimated that over 80,000 children will have been orphaned by the year 2000 due to parental deaths caused by AIDS. Non-infected children and adolescents also may be affected through their association with peers or significant others who are HIV positive, have AIDS, or who have lost loved ones due to AIDS.

HIV/AIDS in Children and Young Adults: As of June, 1996, over a half a million (548,102) diagnosed AIDS cases had been reported to the Centers for Disease Control. Approximately 1.3% (or 7,296) were children less than thirteen years old. This is a significant increase from the 3,898 pediatric AIDS cases reported just three years before in 1992. Relative to adolescents, the incidence of AIDS also is considered to be large and increasing. In fact, AIDS is considered to be one of the leading causes of death among teenagers, and it is estimated that two individuals under the age of 25 are infected with HIV every hour. AIDS is also the leading cause of death for people between the ages of 25 to 44 in the United States. This is significant because it is believed that many of the young adults currently infected with HIV/AIDS may have contracted the HIV virus during adolescence. Thus, adolescent incidence figures may underestimate those who contract HIV but do not exhibit its symptoms until early adolescence.

Relative to gender, HIV is being contracted more rapidly by women, including young girls and adolescents, than by men. Critically, the large and increasing number of females with AIDS also increases the probability of children being born with HIV due to pre-natal or peri-natal transmission. It is estimated that 25% of infants born to HIV-infected mothers will themselves become infected. These children represent one of the fastest growing groups testing positive for the HIV virus.

Definitions:

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What We Know About HIV/AIDS

Transmission: HIV is transmitted through blood, semen, vaginal fluid, and in some cases, breast milk. This allows for many possible modes of transmission including the following:

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It is critical to note that HIV is not transmitted through casual contact.

Prevention:

- Abstinence from sexual activity
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It is critical to note that condoms are not 100% effective but greatly reduce the risk of HIV transmission.

Facts about AIDS:

- You cannot tell if someone has AIDS by looking at them.
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Impact of HIV/AIDS on Children and Adolescents

Many issues relative to academic and social development and functioning arise for children and adolescents with HIV or AIDS. In addition to the physical implications of HIV/AIDS, there are various neurological and psychosocial implications as discussed below.

Physical Implications: HIV infection suppresses the immune system making persons testing positive for HIV vulnerable to opportunistic infections and illnesses which include, but are not limited to, certain forms of cancer, pneumonia, and fungal infections. Therefore, the physical symptoms experienced by persons with HIV or AIDS will vary according to their physical condition and the impact of these illnesses. HIV-infected individuals who have not been diagnosed with an opportunistic infection may also experience generalized symptoms associated with immune suppression such as fatigue, diarrhea, weight loss, fever, and night sweats. To date, there is no cure for AIDS; however, pharmacological therapy (e.g., anti-retroviral medications, protease inhibitors) is used to prolong the onset of symptoms.

Neurological Implications: An estimated 75% to 90% of children infected with HIV experience neuropsychological deficits resulting from developmental delays and/or cognitive disabilities. It is known that HIV infection can interfere with the normal brain development of children, resulting in neurological damage. This is especially true for children infected through perinatal transmission, whose central nervous systems are not yet fully developed at the time of infection. Among other cognitive dysfunctions, visual and auditory short-term memory loss, attention deficits, language disorders, spatial ability problems and expressive and receptive language difficulties may be observed in pediatric AIDS cases. Furthermore, moderate to severe mental retardation is associated with certain neurological disorders caused by HIV.

While HIV-related neurological impairment in children is commonly associated with cognitive delays, neurological impairment in adolescents is more commonly associated with cognitive deterioration. Neurological damage commonly results in the death of children with AIDS Anti-retroviral medications, as well as medications which help to prevent serious opportunistic infections, are thought to be partially responsible for extending the life of HIV-infected individuals. However, the quality of life for such individuals can be negatively affected by subtle, progressive and insidious problems directly resulting from HIV infection, including neurological impairment. HIV infection and AIDS not only impact the immune system, but also the central nervous system. In fact, it is hypothesized that HIV may directly infect the brain. As such, neurological impairment may result from either a direct attack on the central nervous system or through opportunistic infections that the body cannot stop due to HIV or AIDS.

While HIV-related neurological impairment in children is commonly associated with cognitive delays, neurological impairment in adolescents is more commonly associated with cognitive deterioration. Neurological damage commonly results in the death of children with AIDS.

Social Implications: Many of the symptoms reported by children with AIDS are similar to those experienced by children living with other chronic illnesses. Such symptoms include loss of abilities, physical impairments and the fear of impending death. Each of these may result in psychological reactions, including anxiety and depression. However, the social experiences of HIV-infected children differ from those of children with other chronic illnesses in several ways. First, many HIV-infected children, especially those who contract the virus perinatally, may have to cope with losses associated with AIDS-related illnesses and deaths within their families. Second, HIV-infected children are likely to experience additional risk factors: chronic poverty, housing problems, nutritional problems, poor access to medical and social support services, and exposure to violent or dangerous neighborhood environments. Third, and most important, is the stigma associated with HIV/AIDS. AIDS-related stigma is the result of both fear and discrimination. Attempts have been made to deny rights to individuals infected with HIV/AIDS, including the right to employment and the right to a free and appropriate education. Although federal and legal mandates attempt to protect the constitutional rights of people with AIDS, stigmatization and discrimination persist.

What Can I Do as a Teacher?

- Teachers have a responsibility to educate themselves about HIV/AIDS. Teachers must be knowledgeable about the modes of transmission and the modes of prevention if they are to educate their students about how to protect themselves. Also, knowledge about transmission and prevention is necessary to calm their own, students', and parents' concerns about children with HIV or AIDS who are being educated in a regular classroom setting. Teachers can educate themselves by taking courses offered by the American Red Cross (see the Resource section below for an 800 number) or other local community agencies.
- It is a well-documented fact that children model adults', including teachers', behavior. Therefore, it is important that teachers model appropriate behavior that emphasizes problem solving and informed decision-making. It also is critical that teachers model behaviors that discourage discrimination and prejudice against persons with HIV/AIDS. This type of modeling by teachers not only impacts students in their own classrooms, but also the school buildings in which they work.
- Teachers should be aware of the relationship between alcohol/drug use and HIV/AIDS. Alcohol and drug use are considered risk factors for the transmission of HIV because: (a) it is a known fact that

alcohol and drug decrease inhibition, thus increasing the likelihood that individuals will engage in high risk behavior such as unprotected sex; and (b) intravenous drug use is known to be a high risk behavior that may result in HIV transmission. There are also many other negative consequences of alcohol/drug use not associated with HIV/AIDS. Therefore, it is important that teachers educate their students about risks associated with alcohol/drug use and attempt to promote abstinence from such substances.

- Teachers should not be fearful if there is a student with HIV/AIDS in their classroom. There are no documented cases of AIDS transmission due to casual contact, biting, fighting, or contact sports.
- It is important to respect students' and parents' right to privacy. Teachers should be aware of and abide by confidentiality/disclosure laws and policies within their school building and district.
- Universal precautions should be maintained when coming into contact with blood or other bodily fluids that may contain blood. Universal precautions refer to the use of gloves and disinfectants when in contact with blood or blood-contaminated products.

In response to the growing number of school-age children and adolescents infected or affected by HIV/AIDS, schools have been forced to address important issues relative to this disease. The presence of students with HIV/AIDS in the schools has created a controversy for some relative to social, legal, and moral issues. In fact, there have been, and continue to be, debates about the appropriateness of HIV-infected students being educated within regular classrooms. The impact of HIV/AIDS on schools is evident also by debates that continue about what information should be included in HIV/AIDS curricula, and whether such curricula should exist all.

As previously discussed, students with HIV or AIDS present various physical, neurological, and psychosocial problems. In order to intervene, school-based health (including mental health) services must be provided to children, adolescents, and their families. In fact, schools are continually recognizing the impact of health issues on academic functioning, and subsequently, the need for models of health care delivery to be incorporated into educational systems. Schools must work to create academic and social environments that address not only the needs of students with HIV or AIDS, but also the needs of those affected by the AIDS crisis — including peers, teachers, and administrators. Indeed, all members of the school community potentially are affected by this disease, and programs need to be designed to confront this reality. Such programs, ideally, should incorporate the goals of primary, secondary, and tertiary prevention. This type of approach can proactively address the needs of all school members through education and service provision.

Applied here, tertiary prevention focuses on the development of programs and interventions for those already infected and those directly impacted by HIV/AIDS. Secondary prevention targets those groups who are at-risk for contracting HIV, or those groups who will be affected socially, emotionally, financially, or otherwise due to their interactions with an HIV/AIDS infected individual. Finally, primary prevention involves community-wide programs or interventions that make everyone aware of the threat and impact of AIDS. Primary prevention is the most global and pervasive form of prevention, and it ideally creates a foundation reinforcing the need for school, community, and health care communication, coordination, collaboration, and commitment.

Resources

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Florida AIDS Education and Training Centers Network. (1996). Newsletter. Number 16, Winter, 1-12.

Landau, S., Pryor, J.B., & Haefli, K. (1995). Pediatric HIV: School-based sequelae and curricular interventions for infection prevention and social acceptance. *School Psychology Review, 24*, 213-229.

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Wolters, P.L., Brouwers, P., & Moss, H.A. (1995). Pediatric HIV disease: Effects on cognition, learning, and behavior. *School Psychology Quarterly, 10,* 305-328.

Organizations

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Hyde, M.O. (1994). *Know about AIDS* (revised). Walker & Co.

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Silverstein & Silverstein (1989). *Learning about AIDS.* Enslow Publishing.

National
Association of
School
Psychologists

Hospitalization of Children

A Handout for Parents

by Don Brunnquell, Ph.D.
Minneapolis Children's Medical Center

Background

About one-third of children will have been hospitalized at least once before they reach adulthood. Long or repeated hospitalization may create long-term problems, especially if the child has had other stresses such as family problems or significant loss. Short-term effects such as difficulty sleeping, fear of medical treatment, increased limit-testing and changes in activity level are common, but generally disappear within a month after hospitalization. Problems can be minimized and often eliminated by good preparation, communication during the hospital stay and open discussion afterwards.

Development

Children have different needs at different ages in response to hospitalization:

Infancy (0-12 months): Infants need attachment, security and routine. If possible, parents should stay with their infant via "rooming in" at the hospital, and insist on a limited number of caregivers. Help with your baby's care to the extent allowed and maintain the "home schedule" as much as possible.

Toddler (12-30 months): Toddlers still need a feeling of security and routine, but also more independence and help with impulse control. Staying with your child overnight is best, as well as maintaining routines and limiting different caretakers. As developmentally appropriate, involve the toddler in his or her own care and avoid the temptation to be over-protective. As health allows, encourage the toddler to engage in appropriate activity.

Preschooler (age 30 months -5 years): Preschoolers need security, understanding, routines and affirmation of self-worth. It is still best for parents to stay overnight with their child. Help increase the child's comfort with a pre-stay tour of the hospital and provide simple, accurate information about what will happen and why. Reassure the child that hospitalization is not punishment, but avoid over-protection.

Elementary school age (6-12 years): Children at this age need to maintain their sense of self esteem and competence; they are concerned about body image and social status. Help them adjust to their hospital stay by involving them as much as possible in their own care, providing pre-stay tours of the hospital, and by providing them with age-appropriate information about their hospitalization and medical procedures. Encourage visits by family and friends and communication through cards and letters.

Adolescence (12-18 years): It is critical that the adolescent maintain trust, social status and a positive body image. Parents should discuss medical issues and consequences honestly and involve the adolescent in decisions about his or her care. While in the hospital, encourage realistic activities, visits from friends and family, phone calls, etc., to maintain contact with their "normal" world.

What Can I Do as a Parent?

In addition to considering the developmental needs of children at different ages, it is most important to talk with your child about the experience before, during and afterward. While a visit to the hospital may be difficult, preparation and working through feelings can help your child to avoid being overwhelmed. These tips can help your child to see hospitalization as a time to learn and grow:

- Bring your family to a preadmission tour if they are provided.
- Talk to your child before, during and after hospitalization. This is an ongoing process!
- Find out first what your child thinks and feels. Use play, drawings, books, and brief informal chats to explore your child's thoughts and feelings. Then give your child information. Encourage your child to ask questions.
- Younger children think and play in specific ways. Play with them and be as clear as possible. Use play material and role playing as well as words.
- Young children often are especially worried about separation from parents or feel guilty about doing something wrong. Reassure your child that he or she did not cause the illness. Also tell your child that you will come along to the hospital, will take him/her home and that you still love him/her. Bring a stuffed animal, doll, toy or blanket from home.
- Give accurate information in words and ways that children understand. Honesty is important to build trust. It's okay to think about realistic concerns, but help your child to eliminate misunderstandings.
- Help your child to know that "scary" and "hurt" are not the same, that you want to talk about what is happening and that talking helps.
- Encourage normal activities during the hospital stay as much as possible. Games from home, school work, and visits from friends can all help.
- Include brothers and sisters in visits and discussions. They have worries, too and can influence the attitude of the child who will be hospitalized.
- Plan some special celebration or activity for when your child is home again. It helps your child to know that he or she will be coming home.
- Make sure you have the information you need. Talk to your doctor so you feel informed and comfortable. Children know when their parents are nervous, which in turn can make children nervous.

Resources

For medical questions, contact your child's physician. For questions about your child's needs and reactions, contact nursing, psychology and social work staff at the hospital or at your child's school, your child's physician and your own family and friends who have had experiences with hospitalization.

Organization

Association for the Care of Children's Health, 3615 Wisconsin Avenue, N.W. Washington, D.C. 20016.

For Children

Duncan, D. & Ollikainen, N. (1994). *When Molly was in the hospital: A book for brothers and sisters of hospitalized children.* (Mini-med Series , Vol. 1). Rayve Productions. [For children 4-8 years to read or have read to them]

Greenwalk, A. & Heed, B. (1977). *Going to the hospital.* Family Communications. [A Mr. Rogers' book for preschoolers and young children. Informs readers generally about hospitalization and encourages further exploration and discussion.]

Rey, H. & Rey, M. (1966). *Curious George goes to the hospital.* Houghton-Mifflin, Publisher. [In this book for preschool and early school-age children, the familiar monkey character, Curious George, models positive reactions to various aspects of hospitalization.]

Stein, S. (1983). *A hospital story: An open family book for parents and children together.* Walker & Co. [Separate text for parents and children explores the fears surrounding a little girl's hospital stay for a tonsillectomy.]

Original handout published by NASP (1992); resources updated, 1998.

NATIONAL
ASSOCIATION OF
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Lead Poisoning in Young Children

Parent Handout

by Julie McNamara, Thuy Lindsey and Judy Singer
University of Wisconsin-Milwaukee

Background

Lead is a metal that is toxic when consumed and can interfere with the functioning of almost every organ in the body. The ingestion of lead is especially dangerous for children because their developing intestinal track cannot remove lead effectively; therefore it is readily absorbed. One in six children in the U.S. are diagnosed with lead poisoning, according to the Centers for Disease Control (CDC) in 1991. Consequences of lead poisoning can range from various developmental and intellectual delays to more profound impairment including seizures, blindness and, in extremely toxic cases, death. Although it is not known how much lead a child's body can tolerate without adverse effects, current research on lead has prompted the CDC to lower the level of concern to 10 mcg/dl.

It is not unusual for a child with lead poisoning to have no obvious symptoms. Consequently, the majority of cases go undiagnosed and untreated. Primary prevention through universal screening is essential because, although lead poisoning tends to occur more frequently in some communities, no geographic area, socio-economic status or racial or ethnic group is spared of the effects of lead.

Characteristics Associated With Lead Poisoning

- attention and concentration difficulties
- lower scores on intelligence tests
- decreased verbal ability
- hyperactivity
- reading difficulties
- behavior problems
- coordination difficulties
- higher referral rate to special education classes
- poor school achievement
- increased school drop-out rates
- impaired growth and development

Although these symptoms may caused by other problems, lead should not be overlooked as a possible contributor.

Sources of Lead / Children at Risk

Lead-based paint: Lead-based paint is one of the most common sources of lead exposure for children; paints manufactured since the late 1970s do not contain lead. Specific areas of concern in the home are window sills and doorways that are subject to surface abrasion due to opening and closing. Lead-based paint eventually chalks and flakes, creating leaded dust that falls on floors, toys, furniture and other areas in a child's environment. Ingestion occurs during normal, frequent hand-to-mouth activity and by inhalation of leaded dust. Children at risk for this type of exposure are those exhibiting symptoms of *pica* (an abnormal appetite for non-food substances), children living in deteriorated housing, and children living in older housing undergoing renovations (e.g. large amounts of lead may be released into the air by sandblasting).

Soil: Soil may be lead-contaminated with deposits from gasoline, paint or other industrial or occupational sources. Lead is usually deposited in the top few inches of undisturbed soil and does not break down. Children at risk are those living in urban areas, particularly those near freeways and major street intersections, and those living near smelter areas and garbage incinerators where contaminated soil can be a major source of lead in house dust.

Drinking water: Although drinking water is not typically the predominant source of lead poisoning in children, contamination usually occurs in the household plumbing system. Children living in houses with very old (lead) water pipes or in older homes undergoing lead pipe repairs are at risk for lead exposure.

Food: The quantity of lead in the U.S. diet has decreased in recent years due to the restricted use of lead-soldered cans and decreased levels of lead in gasoline. Imported foods continue to be stored in lead-soldered cans. Lead in food may also be a product of the environment in which the plant is grown (contaminated soil, water, or air). Contact with improperly manufactured leaded storage and usage items (ceramic ware, leaded crystal) may contribute to the lead content in food.

Occupations and hobbies: Some occupations and hobbies may contribute to lead levels by transporting lead particles home on clothing or other materials. At-risk occupations include, but are not limited to, auto-repair, construction, firing range workers, workers in battery manufacturing plants, and workers in copper foundries. Some high risk hobbies include pottery, stained-glass activity, furniture refinishing and artistry using inorganic pigments.

What If I Suspect Lead Poisoning?

If you suspect your child has lead poisoning, he or she will need a medical evaluation. It's important to know that there are two types of blood tests — be sure to request the most rigorous test to be sure you obtain reliable results. Your doctor will provide proper medical treatment, depending on the level of lead indicated on the lab results. *Chelation therapy* is a medical treatment in which a lead-attracting agent is administered into the bloodstream to remove the lead for some lead poisoned children. Measures should be taken to protect your child from future exposure to lead, so an environmental investigation for sources of lead and its removal is also recommended. The guidelines in the table below are provided by the CDC with recommended actions for different levels of toxicity.

What Can I Do as a Parent to Prevent Lead Poisoning?

Lead-Based Paint, Soil, and Dust

- Keep young children away from paint chips, chewable surfaces painted with lead-based paints, or dust and soil contaminated with lead. If you are unsure about lead content in your home, your local health officials should be able to offer guidelines for lead detection and possible removal procedures.
- When remodeling your home, consider hiring professionals who are experienced in working with lead-based paint.
- Provide barriers between children and contaminated ground soil by planting grass, bushes or ground covers to surround your home. Particularly avoid exposed dirt.
- Perform weekly wet-washing with cleaning agents high in phosphate (e.g. Spic and Span) on hard surface floors, windows and window sills, doors and other surfaces accessible to children.
- Wash your child's hands, toys, pacifiers and bottle nipples frequently. Teach your children to wash hands frequently.

Water

- Use only fully-flushed water (run for 2 minutes) from your ***cold*** water tap for drinking, cooking or preparing infant formula. In homes with old plumbing, use bottled water.
- Arrange for a professional analysis of your home's water supply by an EPA-certified lab ($30 to $60).

Occupations & Hobbies

- Wash lead-exposed work clothes separately.
- Keep lead-contaminated scraps or waste away from your children.
- Keep all materials and supplies out of your child's reach.

Food

- Use a home lead detection kit to check ceramic ware or lead crystal.
- Imported food cans may be soldered with lead.
- Do not store food in opened cans.

Nutrition

- Provide your child with regular low-fat meals, since more lead is absorbed on an empty stomach. Food high in fat will retain lead longer in your child's system.
- Make sure your children have an adequate intake of iron, calcium, zinc and protein in their diet in order to increase resistance to lead absorption.

Medical Check Ups

- Every child should have a routine blood screening for lead since their exposure may change over time. The highest- risk children should be screened starting when they are 6 months old, since that is when blood lead levels begin to rise. Lower-risk children should be screened for the first time when they are 12-15 months old.

Pre-natal and Post-Natal Exposure to Lead

- Women of reproductive age should be screened for lead, since any lead in the mother's blood can cross the placenta and affect the developing fetus.
- Pregnant women should never be present during home renovations that involve lead-based paint stripping.

Resources for Parents

Childhood Lead Poisoning Prevention: A Resource Directory, a free state-by-state guide to sources of assistance from the National Maternal and Child Health Clearinghouse. 703-821-8955, ext. 254.

The Dish Owner's Guide to Potential Lead Hazards, free from the Environmental Defense Fund, 5655 College Ave., Oakland, CA 9618. Send a business-size SASE.

EPA hot lines: 1-800-LEAD-FYI (for lead).

Thanks to Michael Wilson, school psychologist (Minneapolis Public Schools) for his review and suggestions for this handout.

Appendix

Lead Levels, Symptoms and Recommendations

Lead Levels:	**Possible Complications:**	**CDC Recommendations:**
0-9 mcg/dl	No known problem.	Retest every 12 months to age six. Low risk for high dose exposure. No intervention necessary.
10-14	Risk for mild developmental delays, even if there are no obvious symptoms.	Retest every 6-12 months. Keep children from areas undergoing renovation or where there is likely to be a high concentration of lead dust. Use lead-free water for drinking and cooking.
15-19	No gross symptoms, but child at risk for mild learning problems.	Retest every 6-12 months. Test for iron deficiency. Consider environmental investigation and lead hazard abatement if simple changes do not reduce levels.
20-44	Usually no gross symptoms, but increased risk for intellectual impairment and hyperactivity. (1 child in 100 may have lead levels above 25.)	Complete medical evaluation and chelation treatment may be necessary. Treat for iron deficiency. Identify and eliminate environmental sources of lead.
45-69	Child may suffer from colic, anemia, hyperactivity, abdominal discomfort, constipation or poor concentration.	Medical treatment is required. Environmental assessment and remediation should begin as soon as possible.
70	Severe symptoms may include seizures, coma, mental retardation, and severe abdominal cramps.	IMMEDIATE in-patient medical treatment, environmental assessment and remediation.

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Medications for Children with Behavior and Emotional Problems

A Primer for Parents

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Background

Medications are often prescribed to children and adolescents as part of a comprehensive treatment program for physical illness, health maintenance (as in chronic conditions), neurological and mental health disorders. Because of the many different medications and the many different conditions for which they are prescribed, it can be confusing for parents to consider the pros and cons of prescription drugs for their children. Parents are in the best position to obtain information about medication from the child's physician; however, parents must be aware of the need to ask questions and to read the literature available about each drug. All have the potential to affect a child's health and behavior, not only as expected in treatment, but also as secondary side effects or allergic reactions. Even doctor-prescribed medication can have unforeseen effects. It is therefore essential that parents have a basic understanding of the types of drugs prescribed for childhood disorders, their most common uses and side-effects that might signal the need for medical attention.

The use of drugs for treating children and adolescents with behavior and emotional problems has increased in the last fifteen years due to the availability of new, more effective and safer medications. Research has proven that there is a biochemical basis for many conditions once thought to be caused by family stress, poor parenting or other environmental factors. It is estimated that 2 to 3% of all school children, and 15 to 20% of those in special education classes are taking prescribed *psychopharmacologic* or *psychotropic* medications at any given time. Still, using this type of medication with school-age children remains controversial. Opponents of drug treatment argue that quality educational programming for children and adolescents with behavior and emotional problems is being replaced by attempts to find a quick cure through medication; some also question the relationship between increases in drug prescriptions and managed care. However, research does show that when properly used, some medications can improve the benefits of nonmedical treatments (such as counseling), enhance quality educational programming and allow children to function well in their home and regular school settings.

Basic Facts

Medications are most often labeled by the manufacturer's trade name and a generic name. When a medication is usually effective in treating a particular illness or condition, it is said to be "indicated" or considered potentially appropriate for that condition. In the presence of other medications or physical conditions for which the drug would *not* be recommended, it is said to be "contraindicated."

The intended effect of a drug is to improve the specific condition for which it is prescribed, called the "direct effect." In contrast, "side effects" are not intended, but are secondary to the use of the medicine. Any of the effects may be physical or behavioral, but side effects are less predictable. Changes in behavior or activity level may be observed, as well as physical effects, such as headache, nausea or drowsiness. For example, diphenhydramine, available as Benadryl, is frequently prescribed for colds and allergies in childhood. Side effects may vary; drowsiness or an increase in activity level may be observed. Tetracycline, an antibiotic, is prescribed frequently for acne in late adolescence; nausea is a common side effect of the drug. Parents should be aware that there is usually a range of side effects for each medication; they vary with the type of medication and are reported by physicians and drug manufacturers based on estimates of frequency. This information is helpful to provide guidelines for monitoring your child's reaction to a particular prescribed drug.

Before a new drug is approved for public sale, it must be reviewed by the Federal Drug Administration (FDA). Because so many new drugs are being developed, the FDA has relaxed its rules about how to determine if a drug is "safe" and therefore approved. Physicians can now prescribe drugs that have been approved for one purpose for a different purpose, and can prescribe drugs for children that are approved only for use with adults. This does not mean that the drugs are necessarily harmful for children— it does mean that there has not yet been enough research on the effect of adult-intended drugs when used with children. Therefore, it is very important that parents learn as much as they can about a particular drug, what research has already been done, and what is known about the pros and the cons of the drug for their child's particular disorder.

It is also important to understand how drugs "interact" when two or more are prescribed at the same time. Sometimes one drug will be prescribed to help counter the side effects of another; sometimes the effectiveness of one medication is improved by accompanying it with another. But drugs can also interact to produce different side effects than are found when only one or the other is used. These side effects may be somewhat uncomfortable at first but harmless, or they might cause other health problems. Working with your child's physician and carefully reporting any change in behavior or health will help avert any serious consequences of medication side effects.

Children's Response to Medication

A number of factors determine the degree to which drug effects are predictable; a primary factor is the age of the child. Although in adults, medication effects are fairly predictable, children have a much more variable response. Common concerns include long-term effects of the drug on growth patterns and developing tissue. Medications which affect behavior and cognitive functioning appear to produce qualitative differences in children's behavior or performance, such as the tendency for stimulant medication to decrease motor activity for those under age 10. Individual variability plays an important role in medications' effects; children should be observed for unique reactions, developed on an individual basis. Observations by parents and teachers are needed to determine each child's particular response to each medication for optimal safety and effectiveness. Generally, drug treatment for children is most likely to be effective when combined with nonmedical treatments, such as counseling, family therapy and behavioral interventions at home and school.

Commonly Used Medications and their Effects

There are four major categories of psychotropic medications used with children and adolescents: stimulants, antidepressants, neuroleptics and anticonvulsants.

Stimulants: Stimulants apparently improve behavior and learning in most children with an accurate diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). Stimulant medication enhances attention span which indirectly results in better work productivity and accuracy. While these drugs do not appear to directly improve learning, improved attention and reduced impulsivity can help children benefit more readily from instruction. While positive effects can disappear when stimulants are discontinued, more permanent academic and social gains are found when stimulant medication is combined with other strategies that teach social, study and problem solving skills.

Some stimulant medications are being prescribed to treat ADHD-like symptoms in children with learning problems, Fragile X syndrome, autism and Tourette's syndrome. However, great care must be taken in treating Tourette's Syndrome with stimulants, as some (such as Ritalin) have been shown to increase tics. Recently, physicians have begun prescribing some stimulants in combination with anti-depressants (see below) for conduct and mood disorders, with good results.

Examples: Commonly prescribed stimulants include *Ritalin* (methylphenidate), *Dexedrine* (d-amphetamine) and *Cylert* (magnesium pemoline). Some children respond better to one stimulant over the other, and some children do not respond to any of them. It's unpredictable, but many children continue to benefit from stimulants into adolescence and even into adulthood. A new stimulant, *Adderall*, has possible advantages over Ritalin in that it is longer lasting and has fewer side effects.

Side effects: Stimulant medication's most common side effects are insomnia, decreased appetite, stomach aches, increased heart rate and worsening of symptoms. These side effects are usually short-lived and often prevented by starting with low dosages and increasing them periodically until desired effects are obtained. Infrequent but serious side effects include depression, motor tics, increased blood pressure and growth retardation. Children who develop such symptoms might respond better to a different stimulant or different type of medication, or may need nonmedical treatment to address their attention problems.

Antidepressants are prescribed to treat depression. They are also the second most often prescribed medicine for the treatment of ADHD, and are being used successfully with Obsessive Compulsive Disorder, school phobia, some anxiety disorders and even bedwetting. Usually, these drugs are prescribed along with therapy and school-based interventions. Despite the growing popularity of adult-intended antidepressants, there is little research about the long-term effects of using these drugs with children.

Examples: Antidepressants are divided into three categories: tricyclic (TCA), monoamine oxidase inhibitor (MAOI, aka MAO) and novel or atypical. TCAs such as *Imipramine (Tofranil)* and *Elavil* are prescribed for depression, bedwetting and sometimes ADHD (often with another drug such as Ritalin). TCAs are relatively safe, effective and easy to administer, but are not quite as effective with children and adolescents as with adults; behavioral therapy tends to have better long-term results for most children. MAOs are seldom used today due to the advances in other medications that have fewer side effects; MAOs have not been approved for use with children under age 16 due to potential liver damage.

The newer antidepressants, called Novel or atypical include *Selective Serotonin Reuptake Inhibitors (SSRI)* and others in class of their own. *Prozac (fluoxetine), Zoloft (sertraline), Paxil (paroxetine)* and *Luvox (fluvoxamine)* are in the SSRI group. Also included in the Novel category are non-SSRIs *Welbutrin (bupropion)* and *Desyrel (trazadone)*. While there are no FDA-approved indications for SSRIs in treating children and adolescents, possible indications include major depressive disorder, ADHD, Obsessive Compulsive Disorder, poor impulse control, self-injurious behavior, post-traumatic stress disorder and eating disorders. Used in combination with TCAs, SSRIs appear effective in the treatment of childhood anxiety disorders, with few side effects.

Side effects: TCAs' common side effects include sedation, insomnia, confusion, anxiety, constipation, dry mouth and weight gain. Serious, less common side effects can include irregular heart beats, low blood pressure and seizures. As true with any medication, careful monitoring of children and adolescents taking TCAs is very important. Physicians prescribe this medication under close supervision. The possible side effects of *SSRIs*—seizures, agitation, sedation, insomnia, weight loss, hair loss, headaches, nausea, etc. —can be serious. SSRIs should only be used in carefully controlled situations with children and adolescents.

Neuroleptics are antipsychotic drugs, also known as major tranquilizers and anti-confusional agents. They are mostly used with adults, but the FDA has approved some to used with children less than 12 years of age. These medications are indicated for a variety of emotional and behavior problems including severe psychosis, mania, Tourette's Syndrome, autism, Pervasive Developmental Disorder and self-injurious behavior in school settings.

Examples: Thorazine (chlorpromazine), Mellaril (thioridazine), Navane (thiothixene), Haldol (haldoperidol) and *Compazine (prochlorperazine)* are the most commonly used medications of this type. Two new medications, *Respirdal* and *Clozaril*, have shown promising results with relatively few side effects, but are still considered as experimental in children and adolescents. Another so-called "anti- psychotic" drug, *Lithium*, has been effectively used to treat bipolar (manic-depression) disorder, severe aggression and explosive disorders in adolescents.

Side effects: The side effects of neuroleptics include sedation, mood blunting, lethargy, heart arrhythmia, cognitive dulling, depression, poor muscle tone, tardive dyskinesia, liver toxicity, sudden death, weight gain and a negative effect on attention and learning. Because of the risks of using antipsychotic medications in the treatment of emotional and behavior problems in children and adolescents, there should be a diagnosis of a psychotic or significant mood disorder.

Anticonvulsants are prescribed to treat seizure disorders, but in the last fifteen years there has been a growing trend to use this type of medication with bipolar disorders, major depression, ADHD, conduct disorders and sleep terror disorders in children and adolescents.

Examples: Tegretol (carbamazepine), Depakote/Depakane (valporic acid) and *Klonopin (clonazepan)* might be prescribed to address manic episodes , rage outbursts, aggression and conduct disorder in addition to seizure disorders. Because of serious long-term side-effects, the FDA has not yet approved the use of these drugs with children, although some physicians note that careful monitoring can prevent significant problems.

Side effects: Common side effects for anticonvulsants include lapses in memory and attention, hyperactivity, irritability, aggression, nausea and weight gain. Less common, serious side effects include sedation, confusion, mood swings, tremor and decreased cognitive performance.

Guidelines for Parental Supervision of Medications

Children are not usually attentive, responsible or consistent enough to be in control of their own medication. Schools often have a specific administrative policy to control medicines which are required to be given during the course of the school day; however it is vital that parents be aware of the necessity of supervision and control of children's medications in the home. Safety as well as effectiveness are important considerations that must be stressed. Other considerations:

- Know your child's medication. Learn the generic and trade names, as well as the intended effect of use.
- Administer the medication exactly as directed. "More" does not mean "better." Dosage is determined for your child's height and weight; changing it can be less effective and dangerous.
- Ask your doctor what side effects you can expect. Observe your child after medication and consult the physician in the event of anything unexpected.
- Avoid mixing medications even those sold over-the-counter unless directed by your doctor. Even non-prescription medicines are drugs and warrant caution.
- Store medicines out of the reach of children. Never store more than one medicine in the same container. It is usually best for parents to control access to a child's medication. Discard unused medicines. They can lose effectiveness and/or become dangerous if too old.
- Supervise your child's medications even when used over long-term treatment. Children may not be responsible enough to maintain a regular schedule and may not remember details, such as dosage.
- Inform your child's teachers or other school personnel when medication has been given. Include type, expected effects, and dosage, in the event such information will be needed.
- Know school policy regarding medications at school. Discuss the rules with your child and assist in their enforcement.
- Consult your doctor if unexpected side effects or allergic reactions are observed.

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Medical Management of Behavior and Emotional Problems in Children and Adolescents

A Primer for Educators

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Overview

The use of medication for treating children and adolescents with behavior and emotional problems has increased in the last fifteen years due to the availability of new, more effective and safer medications. Research supports the biochemical basis of many conditions once thought to be based only in dysfunctional family relationships or environmental stress. It is estimated that 2 to 3% of all school children, and 15 to 20% of those in special education classes, are taking mental health (psychopharmacologic or psychotropic) medications at any given time. Still, using this type of medication with school-age children remains a highly controversial topic. Opponents argue that quality educational programming for children and adolescents with behavior and emotional problems is being replaced by attempts to find a quick cure through drugs, and note that many drugs now prescribed for children were approved only for adults. However, public schools today are successfully educating children who not long ago were in special schools or housed in state hospitals. Properly used, medications can increase the success of nonmedical interventions, enhance quality educational programming and allow a student to be educated in a less restrictive, home-school environment.

Commonly Used Psychotropic Medications

Drug research is a rapidly changing science, and research findings supporting new uses for standard medications are common. The U.S. Food and Drug Administration (FDA), recognizing that established regulatory practices cannot keep up with medical research, agreed with the American Medical Association to allow physicians to prescribe any medication approved for marketing for "unapproved" purposes (such as with children) or dosages as they see fit. The FDA is encouraging research to establish the effects of adult approved medications, such as anti-depressants, on children. Meanwhile, millions of young patients are treated with a variety of psychotropic medications, and new medications are introduced every year.

There are four major categories of psychotropic medications used with children and adolescents: stimulants, antidepressants, neuroleptics and anticonvulsants.

Stimulants are the best studied, best validated and most controversial medications used for treating Attention Deficit Hyperactivity Disorder (ADHD). It is estimated that 2% of the school-age population receives stimulant medication for ADHD. *Ritalin* (methylphenidate), *Dexedrine* (d-amphetamine) and *Cylert* (magnesium pemoline) have been the medicines of choice for many years. Some children respond better to one stimulant over the other, and some children do not respond to any of them. It's unpredictable, but most students continue to benefit from stimulants into adolescence and even into adulthood. A new arrival to the field is *Adderall* (a combination of amphetamines) with possible advantages over Ritalin in that it is longer lasting and has fewer side effects. The long-acting formulas available have proven to be less effective at maintaining a therapeutic dose throughout the school day in some students.

Stimulant medications' most common side effects are insomnia, decreased appetite, stomach aches, increased heart rate and worsening of symptoms (including tics). These side effects are transient usually, and avoided by starting with low dosages and increasing them periodically until desired effects are obtained. Abuse of stimulant medication by adolescent patients has been reported but remains to be substantiated by adequate research. A valid concern with stimulant medications is that as the dosage needed to control hyperactivity increases, learning performance decreases in some children. Pediatricians must be cautious in prescribing and maintaining the dosage that enhances learning, although it may not remove all of the symptoms of hyperactivity.

Opponents of stimulants to treat ADHD also argue that, while stimulant medications may enhance attention span and improve productivity, they do not produce significant gains in achievement. Clearly, stimulant medications are not "cognitive enhancers," but many students can work closer to potential in academic subjects when they can block out distractions and focus their attention on the task.

Although not an FDA-approved use, stimulant medications are being prescribed to treat ADHD-like symptoms in below average students, preschool children, children with Fragile X syndrome, autism and Tourette's syndrome. However, great care must be taken in treating Tourette's Syndrome with stimulants, as some (such as Ritalin) have been shown to increase tics. Recent research reports "clinically modest positive effects" when Ritalin is combined with desipramine (an antidepressant) in treating behavior and mood disorders. Also, Cylert has been effective in reducing negative behaviors in some adolescents diagnosed with conduct disorder. Another antidepressant medication, Welbutrin (bupropion), was found as effective as Ritalin in the treatment of ADHD when rated by teachers and parents in well-controlled studies. These findings are significant and add to the physician's ability to combine medications to increase desired results while decreasing side effects.

Antidepressants are prescribed to treat depression. They are also the second most often prescribed medicine for the treatment of ADHD, and are being used successfully with Obsessive Compulsive Disorder and school phobia. Antidepressants are divided into three categories: tricyclic (TCA), monoamine oxidase inhibitor (MAOI, aka MAO) and novel or atypical.

Tricyclics have been around for over fifty years. TCAs are effective in treating major depressive disorders, anxiety disorders, panic disorders and generalized disorders in adults. TCAs are relatively safe, effective and easy to administer, but are not quite as effective with children and adolescents.

The FDA has only approved TCAs for the treatment of bed-wetting and ADHD in children. *Imipramine (Tofranil)* continues to be the drug of choice for bed-wetting, but behavior management still offers a lower relapse rate and best long-term results. Current research and practice suggest that TCAs may also be indicated for the treatment of school phobia, obsessive compulsive disorder and generalized depression in children and adolescents. Research also supports the use of TCAs in combination with other stimulants, neuroleptics and anticonvulsants to treat a variety of psychiatric diagnoses.

TCAs' side effects include irregular heart beats, low blood pressure, seizures, insomnia, confusion, tremors, anxiety and others. As true with any medication, careful monitoring of children and adolescents taking TCAs is very important. Physicians prescribe this medication under close supervision.

MAOs have also been around for over sixty years, but are seldom used today. Newer medications have fewer side effects, patients do not have to follow a strict diet, and are easier to monitor. Currently no MAO compound is approved by the FDA for use with children under age 16 because of probable liver problems. In older adolescents, MAOs could be useful when other medications have failed in treating atypical depression, social phobia and borderline personality disorder with depression.

Novel/atypical: The newer antidepressants, called Novel or atypical are *Selective Serotonin Reuptake Inhibitors (SSRI)* and others in class of their own. *Prozac (fluoxetine), Zoloft (sertraline), Paxil (paroxetine)* and *Luvox (fluvoxamine)* are in the SSRI group. Also included in the Novel category are non-SSRIs *Welbutrin (bupropion)* and *Desyrel (trazadone)*. While there are no FDA-established indications for SSRIs in treating children and adolescents, possible indications include major depressive disorder, ADHD, Obsessive Compulsive Disorder, poor impulse control, self-injurious behavior, post-traumatic stress disorder and eating disorders.

Prozac has become the drug of choice in treating adults because of its relative lack of side effects and withdrawal symptoms. Prozac has also been effective in treating ADHD, but it's a costly alternative. *Luvox* has been effective in treating Obsessive Compulsive Disorders. *Welbutrin* has also been used with success to treat ADHD in children and adolescents and is being used experimentally to treat major depressive disorders in this population. *Desyrel* is not routinely prescribed for children and adolescents. However, Desyrel is a good choice for adolescents who are at risk of overdosing, because it has a low toxicity level. Desyrel is also useful to treat depression with anxiety-related insomnia. Used in combination with TCAs, SSRIs appear effective in the treatment of childhood anxiety disorders, with few side effects. The possible side effects—seizures, agitation, sedation, insomnia, weight loss, hair loss, headaches, nausea, etc. —can be serious, which supports why SSRIs should only be used in carefully controlled settings with children and adolescents.

Neuroleptics are antipsychotic agents and are also called major tranquilizers and anti-confusional agents. They are mostly used with adults, but the FDA has approved some to used with children less than 12 years of age. These medications are indicated for a variety of emotional and behavior problems including severe psychosis, mania, Tourette's Syndrome, autism, Pervasive Developmental Disorder and self-injurious behavior in school settings. *Thorazine (chlorpromazine*), *Mellaril (thioridazine), Navane (thiothixene), Haldol (haldoperidol), Compazine (prochlorperazine), Respirdal (respiridone)* and *Clozaril (clozapine*) are the most commonly used medications of this type. These medications' side effects include sedation, mood blunting, lethargy, heart arrhythmia, cognitive dulling, poor muscle tone, tardive dyskinesia, liver toxicity, sudden death, weight gain and a negative effect on attention and learning. The risks of using antipsychotic medications in the treatment of emotional and behavior problems in children and adolescents without psychosis may be difficult to justify unless it can be clearly shown that the medication makes a major and clinically important difference. Two new medications, *Respirdal* and *Clozaril* have shown promising results with relatively few side effects, but are still considered as experimental in children and adolescents.

Adolescents showing the typical bipolar (manic-depressive) disorder can respond to *Lithium.* Children rarely present with mania but can show cyclic mood and behavior shifts with periods of impulsivity, social intrusiveness, tantrums and mood lability, which sometimes respond to Lithium. Lithium therapy is not FDA-approved for children less than 12 years of age. A major drawback of Lithium is the need for careful monitoring through blood tests, but studies are being conducted to measure Lithium levels through saliva.

Recent Lithium studies have demonstrated that when combined with TCAs Lithium increases the effects of TCAs and can bring relief to patients with major depressive disorders that have not responded to TCA therapy alone. Lithium has also been effective in treating conduct disorders in adolescents when aggressive and explosive behaviors are present. Lithium may be the medicine of choice with aggressive and explosive mentally impaired patients, with fewer side effects than Haldoperidol. In controlled medication trials with anorexia nervosa patients, those who received Lithium gained more weight than those who received a placebo. Lithium, although used for over forty years to treat bipolar disorders, shows promise as a medicine of choice in treating other conditions which have been difficult to treat.

Anticonvulsants are prescribed to treat seizure disorders, but in the last fifteen years there has been a growing trend to use this type of medication to promote mood stabilization. Research has supported the use of *Tegretol (carbamazepine)* in patients with bipolar (manic-depressive illness) disorders, particularly in acute mania. Two other anticonvulsant compounds, *Depakote/Depakane (valporic acid)* and *Klonopin (clonazepan)* have also received a lot of attention. The literature supports the use of Tegretol and Depakote/Depakane as good agents to control manic episodes, rage outbursts, aggression and conduct disorder. The fact that these three medications have the potential for fairly severe long term side effects, such as liver failure, tremors, bone marrow damage, has kept the FDA from approving them for this use. Nevertheless, anticonvulsants are being used today to treat bipolar disorders, major depression, ADHD, conduct disorders and sleep terror disorders in children and adolescents. Supporters of these medications maintain that the serious side effects can be averted by careful laboratory monitoring.

What Can I Do As a Teacher?

The growing trend is to use medication to control certain behaviors in children and adolescents with behavior and emotional problems. Educators are quick to list cases in which medication has had a Jekyll and Hyde effect, making unmanageable children teachable almost overnight. There is little doubt that some medications have proven effective in treating certain conditions. Yet, we must keep in mind that the newer drugs are rarely studied in children or adolescents before marketing, and even the older drugs have been only partially studied in this population. Many mental health medications being used today are still in the experimental stage and should be reserved for clearly distressed or dysfunctional conditions where other treatments have either failed or are only likely to produce short-term results. Medical management of behavior and emotional problems is sometimes justifiable, but there should be strong clinical evidence or benefit. Trials off medication are often indicated to insure the medicine is still making a useful educational difference.

Drug therapy for children and adolescents remains an individual and personal decision between the parents and their physician. Educators should refrain from recommending medicines or dosages with parents unless they have had training in psychopharmacology. Educators, however, are an integral part of the treatment team since proper medication management requires close collaboration between the physician, the parents and school personnel. Effective close collaboration means that each team member:

1. understands the treatment plan and goal(s);
2. is aware of expected behaviors at each step of the treatment plan;
3. knows the possible and probable side effects of the medication(s);
4. knows how to recognize and respond to serious adverse reactions;
5. follows the plan; and
6. remains available to the other team members.

Parents and teachers must remain alert to situations in which medications are being used inappropriately and instead of appropriate educational programming and placement.

Resources

Forness, S.R., Sweeney, D.P. & Toy, K. (1996). Psychopharmacologic medication: What teachers need to know. *Beyond Behavior, 7* (2), 4-11.

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Julien, R.M. (1995). *A primer of drug action: A concise nontechnical guide to the actions, uses and side effects of psychoactive drugs* (7th Ed.). New York: W.H. Freeman & Co.

Shaffer, D., (Ed.). (1992). *Pediatric psychopharmacology.* The Psychiatric Clinics of North America, Philadelphia: W.B.Saunders.

Sifton, D.W. (Ed.). (1997). *Physicians' Desk Reference, 51st Edition.* Montvale, NJ: Medical Economics.

Werry, J.S., & Aman, M.G. (Eds.). (1993). *The practitioner's guide to psychoactive drugs for children and adolescents.* New York: Plenum.

Some of the material for this handout was adapted from Forness et al. (1996), noted in the resource list above, and from material developed by Susan Vess, Ph.D. of the University of Southern Maine.

National
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Obesity in Children

A Prevention Guide for Parents

**by Priscilla Spencer
Philadelphia, PA**

Background

Obesity is defined as an excessive accumulation of body fat. How much fat is "excessive" depends on the height and weight of the child. Between 5%-25% of children and teenagers in the United States are obese. The prevalence of obesity in the young varies by ethnic group. It is estimated that 5%-7% of Caucasian and African-American children are obese while 12% of Hispanic boys and 19% of Hispanic girls are obese. Studies show an alarming rise in obesity among children in the United States during the past twenty years. Not all obese infants become obese children, and not all obese children become obese adults. However, the prevalence of obesity increases with age among both males and females and it is more likely that obese adolescents will be become obese adults.

Impact of obesity: Obesity presents numerous problems for the child. It takes a toll both in physical health and psycho-social adjustment. Childhood obesity is the leading cause of pediatric hypertension, is associated with Type II diabetes mellitus, increases the risk of coronary heart disease and increases stress on the weight-bearing joints. Studies have shown that obese children receive less acceptance from their peers and more discrimination from significant adults in their lives, exhibit a greater sense of rejection and failure, have poorer interpersonal relationships, and have limited group and social interests.

Causes: Childhood obesity most likely results from an interaction of nutritional, psychological, familial and physiological factors. The risk of becoming obese is greatest among children who have two obese parents. Although there is controversy around how much genetic factors play into obesity, parental modeling of both eating and exercise behaviors affects the children. In children, underactivity is a significant source of obesity, and as they grow older their activity levels decrease further.

Treatment: In general, weight loss diets are not recommended for most children. Not only is this approach psychologically stressful, but it may adversely affect growth and the child's perception of normal eating. A child's well-being and adopting a healthy eating and exercise style are more important than pounds lost. Successful behavioral strategies show considerable success in effecting long-term weight loss in both handicapped and nonhanicapped children. The best programs incorporate an exercise component and nutritional training, including slowing the rate of eating, limiting the time and place of eating, and problem solving exercises. Particularly effective are behaviorally based treatments that involve parents.

What Can I Do as a Parent?

1. Obesity is easier to prevent than to treat. Starting in early childhood, teach children proper nutrition, selection of low-fat snacks, good exercise/activity habits and monitor their television viewing.
2. Make good nutrition and exercise a family affair by planning lower fat meals, nutritious snacks and family activities. This makes the child feel included in a total family effort focused and health and not the isolated one with the problem.

3. Do not use food as a reward for an accomplishment, a substitute for love or compensation for a disappointment.
4. Teach children to recognize how their body tells them that they are hungry or full.
5. Encourage children to eat a wide variety of foods in moderation.
6. Do not encourage continued eating or "to clean the plate" when they are truly no longer hungry.

Further information concerning the prevention of obesity in children and adolescents can be obtained from your pediatrician, school nurse and school psychologist. Local mental health departments can inform you about types and availability of intervention programs in your area.

Resources

American Heart Association (1996): *Childhood obesity: Home, heart & stroke A-Z guide.* [On-line]. Available:< *http://www.amhrt.org/hs96/obeskids.htm*>

Eden, A.N. (1975). *Growing up thin.* New York: McKay.

Hassink, S. (1996). *Is my child obese?* [On-line]. Available: <*http:// KidsHealth.org/ parent/ nutrition/ child _obese.html* >

Hirschmann, J. & Zaphiropoulos, L. (1985). *Are you hungry?* NewYork: Random House.

Summerfield, L. (1990). *Childhood obesity.* Washington, D.C.: Colleges for Teacher Education. (ERIC Document Reproduction Service No. ED 328556).

NATIONAL
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Obesity in Children

Information for School Personnel

by Priscilla Spencer
Philadelphia, PA

Background

Obesity is defined as an excessive accumulation of body fat. How much fat is "excessive" depends on the height and weight of the child. Studies show an alarming rise in obesity among children in the United States during the past twenty years. Between 5%-25% of children and teenagers in the United States are obese. The prevalence of obesity in the young varies by ethnic group. It is estimated that 5%-7% of Caucasian and African-American children are obese while 12% of Hispanic boys and 19% of Hispanic girls are obese. For African American girls, however, the trend changes markedly in adolescence, leading to a 50% obesity rate in African American adult women. Not all obese infants become obese children, and not all obese children become obese adults. However, the prevalence of obesity increases with age among both males and females and it is more likely that obese adolescents will be become obese adults.

Impact: Obesity presents numerous problems for the child. It takes a toll both in physical health and psycho-social adjustment. Childhood obesity is the leading cause of pediatric hypertension, is associated with Type II diabetes mellitus, increases the risk of coronary heart disease, and increases stress on the weight-bearing joints. Studies have shown that obese children receive less acceptance from their peers and more discrimination from significant adults in their lives, exhibit a greater sense of rejection and failure, have poorer interpersonal relationships, and show limited group and social interests. Also, obese children demonstrate a higher level of anxiety and depression and a greater incidence of personality disturbances. Overweight children must contend with society's standard of thinness as well as intense social pressure from family and friends.

Causes: Childhood obesity most likely results from an interaction of nutritional, psychological, familial and physiological factors. The risk of becoming obese is greatest among children who have two obese parents. Although there is controversy around how much genetic factors play into obesity, parental modeling of both eating and exercise behaviors affects the children. In children, underactivity is a significant source of obesity and, as they grow older, their activity levels decrease further. Urban poverty is also a significant factor related to obesity, likely due to the impact of family stress, fewer active recreational opportunities and easy access to fast "junk" food versus fresh produce.

Treatment: In general, weight loss diets are not recommended for most children. Not only is this approach psychologically stressful, but it may adversely affect growth and the child's perception of normal eating. A child's well-being and adopting a healthy eating and exercise style are more important than pounds lost. Successful behavioral strategies show considerable success in long-term weight loss in both handicapped and non handicapped children. The best programs incorporate an exercise component and nutritional training including slowing the rate of eating, limiting the time and place of eating, and problem solving exercises. Particularly effective are behaviorally based treatments where parents are active participants.

What Can Schools Do?

The school has increasingly been recognized as an ideal environment for the prevention and treatment of obesity. Starting in early childhood, children can be educated in proper nutrition, selection of low-fat snacks, good exercise/activity habits and monitoring their television viewing. Schools have daily contact with children over long periods of time, are more cost-effective, facilitate early identification and treatment, have the potential for reaching large numbers of persons, and include important social aspects of children's environments. School-based programs, particularly those incorporating behavioral changes and exercise, have been successful in promoting weight loss. Including school personnel, the family and children's peers in weight programs offers even more promise.

School psychologists, social workers, counselors and nurses are in an excellent position to promote effective weight change. They can have frequent and continued contact with a child over an extended period of time, which is a necessary component of successful long-term weight loss. Further, they can enlist the assistance of other support systems such as the child's family, teachers and friends.

Resources

Sheslow, D. & Hassink, S. (1997). Obesity. In G. Bear, K. Minke & A. Thomas (Eds.), *Children's needs II: Development, problems and alternatives* (pp. 897-907). Bethesda, MD: National Association of School Psychologists.

Summerfield, L. (1990). *Childhood obesity.* Washington, D.C.: Colleges for Teacher Education. (ERIC Document Reproduction Service No. ED 328556).

Williams, C. & Kimm, S.(Eds.). (1993). *Prevention and treatment of childhood obesity.* New York: The New York Academy of Sciences.

Websites

American Heart Association: *<http://www.amhrt.org/hs96/obeskids.htm>*
[See online publication: *Childhood obesity: Home, heart & stroke A-Z guide.*]

KidsHealth: *<http:// KidsHealth.org/ parent/ nutrition/ child _obese.html >*

National Eating Disorders Organization (NEDO):
<http://www.laureate.com/nedointro.html> [Home page with links to various resources]

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Prematurity

A Handout for Parents and Educators

by Sherri L. West, University of South Florida
Revised by Louise Masin Sattler, Columbia MD
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Defining Prematurity

Although medical experts agree that "premature" infants face some risks for difficulties in development, there is no one accepted definition of "premature." In the past, "premature" was the label given to infants who were not as well developed at birth as normal babies. The World Health Organization defines a ***premature infant*** as weighing less than 2500 gms (5 1/2 lbs) with no mention of gestational age. Most developmental psychologists use the term "***small for gestational age***" to refer to infants who are small but born full-term; in contrast the term ***"low birth weight"*** is usually used for infants weighing less than 2500 gms without mention of gestational age. However, there are essentially two very different types of premature infants. ***Preterm*** infants are babies born prior to the 37th week of the full gestational period (42 weeks). The second type, termed ***small for gestational age or low birth weight,*** are those infants who were carried the full 9 months, but failed to gain sufficient weight (less than 2,500 grams or 5 1/2 pounds). Each type of premature infant is at-risk for developmental problems.

Development

The medical technology of today gives premature infants a better chance than those born only a decade ago. These improvements are helping to reduce some of the developmental consequences these infants may experience in the future. Developmental differences between premature infants and their normal term counterparts may diminish over the first few years of life. This will depend, however, on the severity of complications at birth (i.e., lungs fully inflated, etc.) and actual birthweight. Recent research has found clear differences in outcomes for Low Birthweight (1500 to 2500 gm) versus Very Low Birthweight (less than 1500 gm) infants. However, the outlook for many premature infants is not as gloomy as was believed in the past. Recent follow-up studies have suggested that the influence of the environment is extremely important in the future development of premature infants. Thus, parents who may feel their lives are "out of control" in caring for a premature infant actually can help make a positive difference in their baby's development.

Developmental milestones should be measured according to the child's gestational age rather than actual birth date. To calculate this date, subtract the number of weeks the baby was premature from the chronological age. Therefore, a 10-week-old premature infant born at 32 weeks will more closely resemble a newborn full-term infant. Parents can then follow standard developmental charts for infant and toddler development using the corrected age. Generally, developmental experts note that this calculation is not necessary after age two years.

The Causes of Prematurity

It is estimated that the cause of approximately 50% of all premature births is unknown. Therefore, many parents are both unaware and unprepared when a premature birth occurs. Parents should understand that many premature births are the result of factors outside of their control. However, researchers have identified some factors that seem to be associated with premature births. These factors may increase the risk of a premature birth; an awareness of these factors may help prevent premature births in the future:

Factors Associated with Preterm Delivery

- previous preterm birth
- multiple pregnancy
- teenage pregnancy (under age 17)
- becoming pregnant within 3 months of giving birth
- previous termination of pregnancy
- low maternal weight
- maternal short stature
- poor maternal nutrition
- poor weight gain in pregnancy
- heart disease
- infection of the urinary tract in pregnancy (cystitis)
- major illness or operation during pregnancy
- separation of the placenta
- single or unsupported parent; divorced
- low socioeconomic status of baby's mother
- heavy smoking by mother
- alcoholism in mother
- drug addiction of mother
- long stressful journeys

What Can I Do as a Parent?

Provide tactile stimulation: After the baby is born, a hospital stay is usually necessary. While the baby is in the hospital, isolettes (incubators) are often used to regulate the baby's body temperature, as well as to provide a protective environment in which to grow. However, parents will probably not be able to hold their premature infant right away and this can cause distress for both parents and infant. Therefore, it is extremely important for parents to visit their infant regularly and take every opportunity to stroke, massage, or rock the infant for tactile stimulation.

Provide both visual and auditory stimulation: This enrichment can be accomplished by using mobiles and pictures for visual simulation. Simply talking and/or singing to your baby will provide the auditory stimulation necessary. Some hospitals request that mothers tape record themselves reading a story to the infant, as this can calm the infant when in distress and the parents are unable to be there. Studies have shown that infants provided with such stimulation gained weight and improved their motoric ability and visual alertness. Though the infant is very fragile and surrounded by medical equipment, the infant's need for love and affection is just as critical for improved health. Parents should become familiar with parent groups and infant stimulation programs in their area. Most medical centers, hospitals, and mental health agencies will be able to provide you with this information.

Provide bonding opportunities: For many years parents of premature infants were told that the parent- child bond would be irreparably harmed because they could not hold their infants at birth. Research has clarified that bonding isn't instant and is a process that occurs over several months of nurturing and caring for your child. There are many ways for parents to begin the bonding process without holding (e.g., getting involved in the child's care, touching, talking, making eye-to-eye contact, etc.).

Keep careful records: parents of premature children need to take careful notes in the form of a journal or scrapbook. First, this assists with the later reporting of the child's birth history; and secondly, it helps frame the experience of the family. Often parents are so caught up in the medical care of the child that they don't take the time to celebrate the birth in terms of collecting memories and well-wishes. However, record-keeping will help parents through some of the more difficult days ahead. A journal also helps to vent some of the anger that parents may feel. The birth of a premature infant can make parents feel very much as if they have experienced a traumatic loss. Dreams of holding your infant or taking him/her home days after the birth are negated. Many parents may feel resentful of this "change in plan" and also feel very vulnerable because they do not understand all of the medical jargon needed to feel a part of the decision-making regarding their child's medical care.

Ask about the risk of Sudden Infant Death Syndrome (SIDS). New parents should be informed of new medical precautions. Preventative information is available from the SIDS Alliance, which can also provide any needed grief counseling.

Learn CPR: All caregivers (parents, grandparents, day care workers) should know and be able to use CPR. In addition, obtain information about apnea/cardiac monitors as well as pneumocardiograms. Discuss these with your physician.

Get information and support regarding breast feeding decisions: Breast feeding a premature baby is different than a full-term infant. Because the baby needs to eat more often but for a shorter duration, this becomes a physically exhausting experience for the mother. Support groups for breast feeding mothers are available. Physicians often recommend breast milk for premature infants due to their sensitive digestive systems. Therefore, a mother who had not intended to breast feed may feel guilty about this decision. Again, seek support groups and counseling for parents of premature babies.

Obtain information about development and available support services: Services may be available from your local school district or hospital programs that follow premature infants and their development. Babies who exhibit significant delays may be eligible for services through Early Childhood Special Education and Individual Family Service Plans. Many premature infants will "catch up" by the time they enter school, but many are also at risk for a variety of developmental difficulties, including Attention Deficit Disorder (ADD) and learning disabilities. Early intervention can prevent or minimize these and other problems.

Resources for Parents and Educators

Bagnato, S.J. & Neisworth, J.T. (1994). *Assessment for early intervention: Best practices for professionals.* New York: Guilford.

Berk, L. (1997). *Child development* (4th Edition). Needham Heights: MA: Allyn & Bacon.

Eisenberg, A., Murkoff, H. E., & Hathaway, S. E. (1989). *What to expect the first year.* New York: Workman Publishing.

Newman, L. F., & Buka, S. L. (1991). Clipped wings. *American Educator*, 27-33

Redshaw, M., Rivers, R., & Rosenblatt, D. (1985). *Born too early: Special care for your preterm baby.* New York: Oxford University Press.

SIDS Alliance: 1314 Bedford Av Suite 210, Baltimore MD 21208; (800) 221-7437.

This handout was originally prepared by Sherri West (1992); additional material was provided for this revision by Louise Masin Sattler (Columbia, MD) and by Tracy Simonson, Ph.D., Miami University of Ohio (1998).

NATIONAL
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Seizure Disorders

Information for Parents

by Lorene R. Heuvelman
Hillsborough County (Tampa, FL) Schools

Background

Epilepsy, by definition, means recurrent seizures. Seizures, which can be described in many different ways, such as convulsions, brief periods of unconsciousness or a change in behavior, affect about 2 million people in the United States. Incidence research has found that nearly 10% of the population will experience a seizure at some point in their life but 50 to 75% of those individuals will *never* have a second episode, and over the lifespan, there is only a 1.4% to 3.3% chance of an individual developing a seizure disorder. However, most seizure disorders begin in early childhood.

Nearly 50% of all seizures have causes that can be identified. These are labeled *Symptomatic or Secondary Seizures.* The remaining seizures are labeled *Idiopathic or Primary Seizures.* In children, idiopathic seizures account for a greater proportion of seizures than symptomatic seizures. In adults, the opposite is true.

Development

The cause of the seizure assists the physician in diagnosis and treatment. *Symptomatic seizures* can occur for many reasons. A high fever (105°+) may cause an event known as a *febrile*, or fever-induced, convulsion which is most commonly found in young children but can affect anyone, at any age. It is thought there is a connection between genetic predisposition and febrile seizures. In some children with low genetic resistance to seizures, fever-related seizures can occur with temperatures as low as 101°. Freeman and his colleagues also report that febrile seizures usually peak at 18 months of age and most children outgrow them by the age of 5 years. Other symptomatic seizures may be instigated by a tumor in the brain, but these are rare and most are treatable. Freeman and others also describe *Post-Traumatic Seizures* which are those that are provoked by an illness or an injury. A trauma to the head (e.g., fall from a bike without a helmet), an infection (e.g., meningitis), increased physiological arousal (e.g., excitement, lack of sleep), breath-holding spells (e.g., associated with "terrible twos") or toxins (e.g., lead based paint) are potential provokers of seizures.

In contrast to symptomatic seizures, *Idiopathic Seizures* are not the result of an illness or injury, but are recurrent seizures which lack a known cause or are related to an anomaly in brain development. Most idiopathic seizures are of the former type. If a child is considered to have idiopathic seizures, the child will most likely be diagnosed with either *Epilepsy* or a *Seizure Disorder.* The latter is the most common term used today.

Once the cause is determined, the seizure is categorized according to the classification system which was revised in the early 1980s. Previously, seizures were categorized as "grand mal or petite mal" but these terms did not adequately illustrate the symptoms of a seizure and, therefore, were abandoned in favor of a more diagnostic classification based on the true characteristics of a seizure. *Partial Simple or Partial Complex* and *Generalized* are the descriptors now accepted to define types of seizures.

Partial Seizures: If the seizure stays contained within a small, localized area it is classified as a *Partial* seizure. *Partial Simple* seizures are those which do not alter consciousness or awareness but can have motor, somatosensory and/or autonomic symptoms (e.g., sensations, thoughts). *Partial Complex* seizures are those which alter consciousness.

Partial seizures are the most difficult for young children to manage since they are aware of the sensations and thoughts but may not understand them. Young children lack the skills of easily distinguishing fantasy from fact and labeling and understanding unusual emotions and behaviors. Because disturbances of thinking and unusual emotions and behaviors are displayed, the family is faced with providing coping skills for the child. Therefore, it is very important that parents become knowledgeable about what is happening in the child and how to manage it with him/her. Partial seizures also can alter behavior, making the seizures look similar to hyperactivity. This makes it very difficult for the child to attend to class work, stay within his seat and she may even fall asleep. He/she may be irritable, impulsive and restless.

Generalized seizures are those in which the entire brain is involved, consciousness is impaired, and can be either convulsive or non-convulsive in nature. *Absence* seizures affect the entire brain, are non-convulsive, and manifest themselves as glazed looks and stares. These seizures occur for only seconds, cause the child to be unaware of the seizure, and are often mistaken for daydreaming. In contrast to popular belief, absence seizures are rarely found in children. *Myoclonic* seizures are convulsive and cause the muscles to jerk. There is no mistaking this type of seizure since the whole body is usually involved and the child looks as though he/she has been jolted by an electrical shock. *Atonic* seizures make the child lose tone or posture as though the child cannot support his/her body and he/she goes limp. *Tonic-Clonic* seizures are a combination of myoclonic and atonic seizures. The muscles tighten and go limp in a rhythmic fashion. These types of seizures are most commonly found in children, but not in adults, and do not typically result in brain damage or death despite popular beliefs.

Impact of seizures: Parents and teachers want information about effective treatments and possible side effects on intellectual and social/emotional growth. These are important concerns; unfortunately, good empirical research is lacking on the latter. Most experts believe that children with a seizure disorder do not suffer developmental delays or learning and emotional disabilities. Research has indicated that the more severe the seizures, the more generalized the affected area of the brain, the longer the duration, and the earlier the onset all increase the likelihood of cognitive impairment. Therefore, it is important to reduce the possible negative side effects on development by consistent medical treatment, follow-up, and supervision from both parents and teachers. Of those children who do have some cognitive impairment, special education is often warranted. Parents are encouraged to become very familiar with the rights of their children when dealing with schools and special education programs and teachers.

Treatment

There are only a few treatments for seizures, but fortunately they are usually very effective. Medication seems to be the most respected treatment to date as the seizures of most children with a seizure disorder are controlled by this means. Physicians today find themselves among an array of drugs from which to chose and most seizure disorders are controlled by using only a single drug. Most importantly, the drug selected depends on the type of seizure the child experiences. Other factors considered include the child's age, health, frequency and severity of seizures and possible side effects. The parents should be informed that medication treatment requires an approach that appears haphazard but is really quite experimental. The physician attempts to control seizures with the smallest dose of a drug possible to reduce any potential side effects. Thus, small doses are usually prescribed, and in the event of a seizure, the dose is increased. This will continue until the lowest dosage possible is controlling the seizures. If the drug is unsuccessful, a new drug is usually added to determine if it is effective in controlling the seizure. This process can take up to a year or more.

Other treatments include surgery, biofeedback and psychotherapy. However, biofeedback and psychotherapy have been more helpful in providing coping strategies for individuals to deal with other aspects of having a seizure disorder (e.g., anxiety over having a seizure and where they may happen, social stigma) rather than the control of the actual seizure itself.

What Can I Do as a Parent?

As a parent, there are many steps you can take if your child has a seizure. The most important step is good medical care and follow-up to manage the physical effects of the seizure. Tests may be requested which include electroencephalogram (EEG), CT scan, and magnetic resonance image (MRI) to assist in the diagnosis and treatment. If the child is diagnosed with a seizure disorder and treated with medication, you will need to have blood drawn at various times to check the levels of the medication to determine its effectiveness in controlling the seizures.

Second, you will want to educate yourself and your family about a seizure disorder, possible treatments and prognosis. Write down any questions you may have about seizures and the observations you made during a seizure for the physician to review. A pediatric neurologist will usually be consulted and the test results (e.g., EEG, MRI) will be discussed with you.

Third, you need to learn how to manage each seizure and reduce its potential side effects. Although a seizure disorder is serious, few symptoms are considered life-threatening. There are a number of steps which can be taken to reduce the impact of the seizure on the child. The following reminders are provided and include moving sharp objects out of the child's way, remembering the child feels nothing during the seizure, placing the child on his/her side so he/she does not swallow vomit that may emerge, and expecting a temporary blueness or paleness of the lips and body. It is vital that those around the child stay calm since the doctor relies on detailed information to assist in accurate diagnosis and treatment. The parents are advised to observe the length of the seizure, the child's behavior after the seizure, and to determine what happened before the seizure began.

Factors to Consider

You will need to learn to manage your own reactions to the disorder and assist your child in understanding and managing his/her disorder. As a parent, you are the primary instructor and role-model in your child's life. Therefore, his/her positive social/emotional growth is dependent upon your guidance. You need to consider the following questions:

Does my child make statements about being different or weird in comparison to his/her playmates?

Does my child withdraw or isolate himself/herself from other children?

Is my child more anxious than other children when participating in group activities (i.e., sleep overs, contact sports or games)? Is this anxiety or a sign of a more serious worry that he/she may have a seizure?

Do others tend to respond differently to my child when they learn of his/her seizure disorder? If so, is my child aware of it?

Suggestions

Depending on the answers to the above questions, the following suggestions might be helpful:

Listen, listen, listen to what your child says.

Talk openly about the disorder and explain, in age-appropriate terms, what it means to have a seizure disorder. Ask the physician to do the same.

Be honest about the prognosis; depending on the type of seizures and the etiology, tell your child that there is a possibility that he/she could grow out of it, but that it remains to be seen.

Try to normalize the disorder by letting your child know that everyone has something about them that makes them a little different.

Encourage your child to talk to you about his/her feelings and how others may have treated him/her differently because of the disorder.

Talk to your child's teacher about including a discussion with the class on seizure disorders. If the teacher does not feel he/she can lead a discussion of this type, call your local Epilepsy Foundation organization for information and speakers. Or, you might lead the discussion since you have already learned so much about the disorder.

Encourage your child to ask questions of the physician himself/herself. Give your child some control over learning about the disorder.

Go to the library with your child or as a family to research seizure disorders together. Let him/her know that the family is all in this together and that he/she is not alone.

Resources

Your best resource is your pediatrician or neurologist. They can inform you about the many facets of the disorder than could not be described in detail here. They should also have current reading materials or resources that you can get at your local library. It is important to have the most up-to-date information since the last two decades have brought an increase in possible medications and treatments for seizures. In addition, seizures have been masked behind behavioral difficulties, and when properly diagnosed and treated, do not recur. Other resources at your library or bookstore:

Freeman, J. M., Vining, E. P. G., & Pillas, D. J. (1991). *Seizures and epilepsy in childhood: A guide for parents.* Baltimore, MD: Johns Hopkins University Press.

Jan, J. E., Zeigler, R. G., & Giuseppe, E. (1991). *Does your child have epilepsy?(second edition).* Austin, TX: Pro-Ed.

Reiser, H. (1988). *Children with epilepsy: A parents' guide.* Kensington, MD: Woodbine House, Inc.

Websites and Organizations

Epilepsy Foundation of America — 800-EFA-1000. Homepage: *<http://www.efa.org>* [FAQ, bookstore, links to other resources, "Kid's Korner"]

National Epilepsy Library Data Base: *<http://www.neuro.wustl.edu/epilepsy/linkresources.html/>*

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Seizure Disorders
Information for Teachers

**by Lorene R. Heuvelman, Hillsborough County (Tampa, FL) Schools
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Background

Epilepsy, by definition, means recurrent seizures. Seizures, which can be described in many different ways, such as convulsions, brief periods of unconsciousness or a change in behavior, affect about 2 million people in the United States. Incidence research has found that nearly 10% of the population will experience a seizure at some point in their life but 50 to 75% of those individuals will *never* have a second episode, and over the lifespan, there is only a 1.4% to 3.3% chance of an individual developing a seizure disorder. However, most seizure disorders begin in early childhood.

Nearly 50% of all seizures have causes that can be identified. These are labeled *Symptomatic or Secondary Seizures.* The remaining seizures are labeled *Idiopathic or Primary Seizures.* In children, idiopathic seizures account for a greater proportion of seizures than symptomatic seizures. In adults, the opposite is true.

Development

The cause of the seizure assists the physician in diagnosis and treatment. *Symptomatic seizures* can occur for many reasons. A high fever (105°+) may cause an event known as a *febrile*, or fever-induced, convulsion which is most commonly found in young children but can affect anyone, at any age. It is thought there is a connection between genetic predisposition and febrile seizures. In some children with low genetic resistance to seizures, fever-related seizures can occur with temperatures as low as 101°. Freeman and his colleagues also report that febrile seizures usually peak at 18 months of age and most children outgrow them by the age of 5 years. Other symptomatic seizures may be instigated by a tumor in the brain, but these are rare and most are treatable. Freeman and others also describe *Post-Traumatic Seizures* which are those that are provoked by an illness or an injury. A trauma to the head (e.g., fall from a bike without a helmet), an infection (e.g., meningitis), increased physiological arousal (e.g., excitement, lack of sleep), breath-holding spells (e.g., associated with "terrible twos") or toxins (e.g., lead based paint) are potential provokers of seizures.

In contrast to symptomatic seizures, *Idiopathic Seizures* are not the result of an illness or injury, but are recurrent seizures which lack a known cause or are related to an anomaly in brain development. Most idiopathic seizures are of the former type. If a child is considered to have idiopathic seizures, the child will most likely be diagnosed with either *Epilepsy* or a *Seizure Disorder.* The latter is the most common term used today.

Once the cause is determined, the seizure is categorized according to the classification system which was revised in the early 1980s. Previously, seizures were categorized as "grand mal or petite mal" but these terms did not adequately illustrate the symptoms of a seizure and, therefore, were abandoned in favor of a more diagnostic classification based on the true characteristics of a seizure. *Partial Simple or Partial Complex* and *Generalized* are the descriptors now accepted to define types of seizures.

Partial Seizures: If the seizure stays contained within a small, localized area it is classified as a *Partial* seizure. *Partial Simple* seizures are those which do not alter consciousness or awareness but can have motor, somatosensory and/or autonomic symptoms (e.g., sensations, thoughts). *Partial Complex* seizures are those which alter consciousness.

Partial seizures are the most difficult for young children to manage since they are aware of the sensations and thoughts but may not understand them. Young children lack the skills of easily distinguishing fantasy from fact and labeling and understanding unusual emotions and behaviors. Because disturbances of thinking and unusual emotions and behaviors are displayed, the family is faced with providing coping skills for the child. Therefore, it is very important that parents become knowledgeable about what is happening in the child and how to manage it with him/her. Partial seizures also can alter behavior, making the seizures look similar to hyperactivity. This makes it very difficult for the child to attend to class work, stay within his seat and she may even fall asleep. He/she may be irritable, impulsive and restless.

Generalized seizures are those in which the entire brain is involved, consciousness is impaired, and can be either convulsive or non-convulsive in nature. *Absence* seizures affect the entire brain, are non-convulsive, and manifest themselves as glazed looks and stares. These seizures occur for only seconds, cause the child to be unaware of the seizure, and are often mistaken for daydreaming. In contrast to popular belief, absence seizures are rarely found in children. *Myoclonic* seizures are convulsive and cause the muscles to jerk. There is no mistaking this type of seizure since the whole body is usually involved and the child looks as though he/she has been jolted by an electrical shock. *Atonic* seizures make the child lose tone or posture as though the child cannot support his/her body and he/she goes limp. *Tonic-Clonic* seizures are a combination of myoclonic and atonic seizures. The muscles tighten and go limp in a rhythmic fashion. These types of seizures are most commonly found in children, but not in adults, and do not typically result in brain damage or death despite popular beliefs.

Impact of seizures: Parents and teachers want information about effective treatments and possible side effects on intellectual and social/emotional growth. These are important concerns; unfortunately, good empirical research is lacking on the latter. Most experts believe that children with a seizure disorder do not suffer developmental delays or learning and emotional disabilities. Research has indicated that the more severe the seizures, the more generalized the affected area of the brain, the longer the duration, and the earlier the onset all increase the likelihood of cognitive impairment. Therefore, it is important to reduce the possible negative side effects on development by consistent medical treatment, follow-up, and supervision from both parents and teachers.

Students with a history of seizures sometimes have significant achievement deficits that might co-exist or be directly related to their seizures and/or side effects of medication. Behavior problems are often observed, including emotional lability, anxiety, irritability and hyperactivity. Again, these problems may be related to underlying neurological problems, side effects of treatment or co-existing conditions. Emotional consequences of having a seizure disorder include higher levels of anxiety (fear of safety during a seizure and/or embarrassment from having a seizure in public) and dependency issues related to feelings of incompetence and loss of control. Additionally, the family stress that naturally accompanies the diagnosis of any chronic disorder can significantly impact the emotional adjustment of the student.

Of those students who do have some cognitive impairment, learning and/or behavioral difficulties, special education is often warranted. Parents may request an evaluation, or school personnel can refer the student to their building support team for consideration of special education or other support services.

Treatment

There are only a few treatments for seizures, but fortunately they are usually very effective. Medication seems to be the most respected treatment to date as the seizures of most children with a seizure disorder are controlled by this means. Physicians today find themselves among an array of drugs from which to chose and most seizure disorders are controlled by using only a single drug. Most importantly, the drug selected depends on the type of seizure the child experiences. Other factors considered include the child's age, health, frequency and severity of seizures and possible side effects. The parents should

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be informed that medication treatment requires an approach that appears haphazard but is really quite experimental. The physician attempts to control seizures with the smallest dose of a drug possible to reduce any potential side effects. Thus, small doses are usually prescribed, and in the event of a seizure, the dose is increased. This will continue until the lowest dosage possible is controlling the seizures. If the drug is unsuccessful, a new drug is usually added to determine if it is effective in controlling the seizure. This process can take up to a year or more.

Other treatments include surgery, biofeedback and psychotherapy. However, biofeedback and psychotherapy have been more helpful in providing coping strategies for individuals to deal with other aspects of having a seizure disorder (e.g., anxiety over having a seizure and where they may happen, social stigma) rather than the control of the actual seizure itself.

What Can Teachers Do?

It is important that all school personnel who have regular contact with a student with a seizure disorder have some basic understanding of the nature of the disorder, the types of seizures the student might display, how to respond, and how to best support the student's school program. A conference with the parents, school psychologist, school nurse and, if possible, medical care providers will help coordinate efforts and open the lines of communication. Teachers should be informed of the symptoms of the student's seizures and any likely side effects of medication. Observations by teachers and other school personnel can be very helpful in monitoring a student's response to treatment and alerting parents and physicians to any changes in behavior, mood or concentration that might signal the need to re-evaluate medication. Other suggestions:

- Know what to do when your student has a seizure at school. Your school nurse, parents and the student's physician can provide information about acute seizure management and symptoms that signal the need for immediate medical attention. If the child is likely to lose bladder or bowel control during a seizure, arrange to have an extra set of clothing at school. Unless medical care is needed, plan for a quick return to normal school activities as soon as possible after a seizure.
- Work with parents, student and your school psychologist and school nurse to provide information to classmates about seizures. Younger children often have misconceptions about seizures and may be frightened by witnessing a seizure or even hearing about it. Work out a plan with the student and his or her parents to inform classmates in a manner that will not embarrass the student with seizures, and at the same time will reduce stigma, fear and confusion. Children who are old enough to learn basic first aid should also learn how to help a student who is having a seizure at school, who to contact for help etc.
- Discuss any activity restrictions with parents. Generally, students with seizure disorders can participate in most or all school activities, sports, etc. Depending on the nature of the student's seizures, some safety precautions or adaptations may be necessary.
- Consider the need for a comprehensive evaluation of learning, behavior or emotional difficulties through the special education team at your school. Some students with seizure disorders will require special education services to optimize learning and minimize behavioral problems. If problems persist despite special education services, the family might be advised to pursue a more thorough medical, neurological and psychiatric evaluation through clinics that specialize in seizure disorders.
- Some students might benefit from counseling through school or community agencies. Your school psychologist or counselor can help the student with seizures to understand the disorder and develop better problem solving and coping strategies in both academic and interpersonal situations. Vocational counselors can be helpful for older students who are considering the impact of their seizures on potential job choices and employment. Parents might also find it helpful to consult their community mental health provider regarding services to address stressors within the family.

Resources

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Some of the material in this handout is adapted from Bailet and Turk (1997), above.

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Sleepwalking in Children

Information for Parents

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Connecticut Department of Children and Families

Background

Sleep disorders are fairly common and are generally classified as being a *dyssomnia* or a *parasomnia*. Dyssomnias are disturbances in the quality, timing and amount of sleep and include such disorders as narcolepsy and insomnia. The parasomnias are stressful events that occur during the sleep cycle but are not significant disturbances of sleep. Sleep terrors, nightmares and sleepwalking are all parasomnias. *Sleepwalking (somnambulism)* occurs in 2 to 5 percent of the general population. Prevalence estimates in children indicate that the behavior can begin by age 6 and that approximately 16 to 30 percent of all children have at least one episode of sleepwalking before the age of 15.

The occurrence of the behavior in a child is usually a frightening experience for parents. The child will typically rise out of bed, move about the house, exhibit good fine and gross motor coordination, and perhaps engage in everyday goal-oriented activities such as eating, drinking or urinating. Many times the child will walk toward the parents' bedroom.

An episode of sleepwalking will occur within three hours of falling asleep and last for about 10 minutes. The child will have little to no awareness of the activity when he awakens and the episode generally ends without trauma. Since the child is able to move about, however, and open doors and windows, there have been times when sleepwalkers have been seriously injured. The behavior, in certain situations, is also indicative of underlying psychosocial difficulties that the child may be experiencing. Generally, it is a behavior that should not be ignored, particularly if it is recurrent.

Development

The causes of the behavior have been linked to psychological, genetic and physiological factors. Children who are under extreme stress, experiencing separation anxiety and/or feelings of insecurity may be prone to sleepwalking behavior. In fact, children and adolescents who are sleepwalkers usually report a significant stressful life event that occurred before sleepwalking behavior began, such as the death of a parent, divorce, birth of a sibling, or school failure. Further, a striking 80 to 90 percent of sleepwalkers have a family history of sleepwalking. Abnormal EEG's (atypical brain activity) have been indicated in some instances of sleepwalking and brain tumors have been found in a small number of cases.

What Can I Do as a Parent?

The behavior is almost always alarming to parents. If the behavior is infrequent, however, there is little reason for concern. In this situation, the sleepwalking should be considered innocuous and not indicative of severe emotional problems. Parents should be informed that children generally outgrow the behavior as they approach puberty.

Rule out a medical problem: If parents begin to notice that the behavior is frequent and intense (e.g., more than one episode per night) there is reason for concern and assistance should be sought. Initially, it is recommended that a physician be consulted to determine if the cause(s) of the behavior is physiological in nature. There is evidence that epileptic seizures, febrile illness and other brain abnormalities can produce behavior similar to sleepwalking.

Consult a psychologist: When physiological factors are ruled out, it may be appropriate to determine if the behavior is psychogenic. A psychologist should be consulted to determine if the behavior is related to stress/separation issues or other emotional concerns. This can be accomplished by obtaining information from caregivers, teachers, significant others, testing and behavior checklists. Developmental, academic, and family history should be obtained. Information such as sleep history, age of onset of sleepwalking, family history of sleepwalking or any other sleep disorder, and the occurrence of any recent stressful life event is essential. If the source of stress can be identified, strategies to reduce the stress and subsequently the behavior can be developed. For example, the child who experiences the divorce of his parents may develop separation anxiety and feelings of insecurity that may manifest itself in sleepwalking behavior. In this situation, it may be necessary for both parents to reaffirm their affection/loyalty to the child, to spend increasing amounts of quality time with the youngster, and to include the child in as many family activities as possible.

Counseling/consultation to assist parents in coping with the behavior and developing stress reduction strategies is sometimes necessary. Counseling with the childhood sleepwalker is, at times, effective. Relaxation techniques, simple biofeedback methods and, in some cases, hypnosis have shown some promise.

Protect child from injury: There is a possibility of injury during sleepwalking. Therefore, it is essential for caregivers to protect their children. Windows and outside doors should have special locks. The child should sleep on the ground floor if possible; if this is not possible then secured gates should be installed at stairways. Dangerous objects should not be accessible to the child. The sleepwalker should not be wakened during an episode. They will not awaken easily, will be somewhat confused, and will usually have no memory of what has happened. It is better to simply watch and ensure that an accident does not occur.

Medications such as antidepressants or antianxiety agents are sometimes used in treating children with frequent and intense episodes but the behavior may increase in frequency when the medication is discontinued. Generally, drug interventions are not recommended for children.

Resources

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Sports Participation for Children

A Parent's Guide

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Background

It is estimated that from 30 to 45 million children ages six through 18 participate in at least one school or community-based athletic program, although school physical education programs account for only 20% of the typical student's physical activity. These numbers seem to increase exponentially as the age of boys' and girls' first forays into organized sports keeps falling; "Tee-Ball" and "Tiny Tots" programs, for example, lure them onto fields and courts throughout the country at increasingly younger and younger ages. Girls' programs also have contributed significantly to the athletic rank and file. Once seemingly the entitlement of males only, the adoption of Title X in 1972 guaranteeing equal opportunity for women in education, including sports, began the process that assured girls that the world of athletics would be open to them.

In order to supervise, teach and manage these aspiring athletes, approximately 2.5 million coaches, mostly volunteer, spend an average of 80 hours per season with them. As the competitive nature of these teams increases, so do the weekly practice hours, making the child's coach almost as prominent a figure in his/her life as the classroom teacher. It would behoove parents, therefore, to become familiar with their children's athletic program, just as they familiarize themselves with their school's program via PTO meetings and Back To School nights. Without a national agency (Little League notwithstanding) to coordinate sports programs for children, there exists a great variation in the manner in which sponsoring agencies organize these teams, thus leaving plenty of opportunity for parents to be involved.

Insuring Benefits from Sports

According to the experts, there are few, if any, areas of a child's development that cannot benefit from organized sports. Goals of agencies that sponsor youth sports programs include the development of social and interpersonal skills, health, fitness and psychological well-being. The more evident benefits involve individual skill development, greater physical fitness and health-mindedness, and higher self-esteem. Less obvious benefits include the development of group cooperation, teamwork and social friendship-making skills. Some skeptics may criticize children's sports programs as causing stress, burnout, psychological trauma and lowered self-esteem, suggesting that participation in sports is hazardous to a child's physical and emotional health. However, sports participation is neither good nor bad, neither a curse nor a cure. Rather, it is dependent upon the context in which it occurs, and it is up to parents to understand this context.

Important factors to consider regarding children's participation in organized sports include the way in which the competitive situation is structured, the personality and family dynamics of the child, and the organizational/managerial style of the coach. Parents' understanding of each of these factors will enable them to make informed decisions about their child's participation in the sport and to insure that the experience is a positive one.

The Team

Teams that are considered instructional in nature are designed for young children (below age eight or so, although this age may vary from league to league) with entry-level athletic skills. These leagues provide many accommodations for the younger player: no scores kept during "games", no league standings and ongoing instruction and feedback during games, with parents usually serving as volunteer referees.

Once past this age, children are eligible to participate in their own community's recreation leagues. These programs simply assign all children to teams, regardless of their individual skill levels, avoiding the fear of rejection, of "being cut". Recreation leagues also mandate minimum playing times for their players.

Climbing the sports ladder brings one to the next step, the most competitive one. Known as "traveling" or "all-star" teams, they place a great emphasis on winning and choose only the best players from the tryout pool. Only the most skillful players of these teams see substantial playing time, with the rest spending much of their time on "the bench." Children who tend to shy away from high intensity competitive situations are not well-suited for this type of team.

The Child

In their need to know where they stand in comparison to others, children will naturally seek out competition as they mature. For them, sports becomes a social process within which they make these comparisons. Nevertheless, knowing one's child is important in order to make sure that there is a comfortable fit with the team and the coach.

Children are not unlike adults who vary in the way they cope with success and failure. Those who cope well take success in stride, but they also manage disappointment and failure without undue harm to their self-confidence. Others tend to personalize failure and take longer to recover from new disappointments, like being "cut" from a team or losing a game. Understanding your child's coping abilities is important, not only to assist in matching him or her with the right type of team and coach, but also to help you monitor your expectations for your child's performance. Expectations that exceed a child's performance potential can exert inordinate pressure on children with poorer coping skills, leading to a loss of self-confidence.

The Coach

The qualities that make a person a good teacher are those that make a person a good coach. Considering the influence that a coach can have on his or her players, it is not unreasonable to suggest that parents ask around about a child's coach as much as they ask around about their child's new teacher. Parents should expect their child's coach to know the sport well enough to be able to teach it during practices that are organized and structured. A good coach also would never belittle a player, nor should a coach lose control of his or her emotions in front of young athletes. She or he also communicates regularly and appropriately with both children and parents.

Using feedback in the appropriate manner is the difference between motivating or discouraging a child. Getting to know the manner in which a child's coach provides this feedback is as important as is the manner in which a teacher grades classroom work.

Look for Coaches Who:

- Provide a high rate of positive relative to negative comments
- Give specific comments about child's performance, not the child as a person
- Give praise most often to factors within a child's control (effort, hard work, determination) rather than those beyond his or her control (winning)
- Are honest and straightforward and avoid false flattery (feedback viewed as insincere actually lowers self-esteem and makes the coach less credible in the child's eyes)

Suggestions for Parents

1. ***Choose a sport that matches your child's interest and personality.*** Does she show an interest in a particular one? Is he outgoing and social and well-suited to a team sport? or quiet and shy and better off with solitary pursuits (swimming, running) ? Does she crave structure and organization, or does she prefer to set her own pace, her own routines?

2. ***Choose a team that matches your child's skill level.*** Check with the sponsoring agency: is the team instructional? Competitive? Will players be assigned to teams with other players of similar ability? Is there a playing time requirement?
3. ***Check the level of commitment expected.*** How long a season? How many hours of practice per week? Keep in mind that children should be free to pursue different sports experiences. Coaches should not expect young children to "specialize" in one sport. In a survey of 63 of the world's greatest athletes, all but five claimed that they didn't specialize in their ultimate sport until they were 16 years of age.
4. ***Make sure your child maintains a balance in his or her life.*** Do not allow sports to be everything. Encourage other interests: music, scouting, etc.
5. ***If your child is self-conscious about her skill level,*** take her aside and work with her privately. Acquiring these skills will lead to increases in self-confidence and greater effort in the future.
6. ***Praise effort, not outcome (winning).*** Avoid comparing one child's performance to another. Rather, compare him to the development of his own individual skill level over time.
7. ***Listen to your child.*** If her interest in a sport wanes, allow her to give it up at the end of the season. However, investigate the reasons for this change; sometimes at the root of this decision are social problems among team members, not a lack of interest in the sport. If this is so, talk to the coach about it.
8. ***Monitor your child's stress level during the season.*** One study found that coaches could predict with only 10% accuracy the level of stress in their players, so it may be up to parents to keep an eye on it.
9. ***Know the "chain of command" of the league.*** If the concerns that you raise with the coach fall on deaf ears, find out whom you can call to discuss the matter further.
10. ***Monitor your own expectations of your child's athletic performance.*** If losing bothers you more than it does her, it may be time to pick up a hobby.

Summary

Organized sports can benefit a child in many different areas. However, more important than just the participation in the sport is the "context" of the sport. The type of team, the type of child and the type of coaching style are all significant factors that can impact the sports experience. If the match among these three factors is not a good one, then benefits may be minimal. However, if the match is right, then sports can enhance physical and psychological health. Understanding and appreciating these factors is an important task for parents.

Resources for Parents

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Teen Pregnancy

Prevention Strategies for Parents

by Faith Marie Beam and Barbara Good
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Background

In the United States approximately 3,000 teenage girls become pregnant every day despite the availability of school-based sex education and family life classes. Research findings of the past thirty years indicate that most adolescents have the values and attitudes necessary for responsible sexual behavior. However, the problem for many young people becomes translating their attitudes and values into personal behavior.

Sex education programs in schools usually provide information about reproduction, venereal diseases, and pregnancy prevention. This knowledge is important for preventing pregnancy. Although many parents voice concern that sex education will increase the likelihood of teen sexual activity, this is not the case. Students completing sex education courses report their first sexual intercourse is at the same age, or a later age as students not completing the course. While sex education does not prevent sexual activity among teenagers, young women who have had a sex education course in school appear to be more effective users of contraceptives. The consistent, effective use of contraceptives reduces the odds of pregnancy among teens who are sexually active.

Unfortunately, one school sex education course by itself does not have a significant affect on the teenage pregnancy rate. Teens receive conflicting sexual messages from television, movies, advertising, peers, and family which often compete with cautions to act responsibly. The task of educating teens about sex must begin with parents. Nationally, 41% of African-American girls and 19% of white girls, and 66% of African-American boys and 32% of white boys become sexually active before the age of 15. When parents are the child's main source of sex education information, adolescents tend to engage in less premarital intercourse, have fewer sexual partners, and delay their first intercourse to a later age. Children need in-depth, explicit information early to allow them to make informed sexual decisions in the future.

Family role models have a major impact on the adolescent's sexual behavior, values, and attitudes. Girls are heavily influenced by their mother's behavior and attitudes about sex. By the time children have reached the age of three or four, they have already received substantial information about sexuality. Even in households where sexually oriented discussions are avoided, children detect and accept attitudes that are revealed nonverbally. While the peer group no longer has the amount of influence it once did as a source of sexual information, children continue to learn about sex at a younger age than either their parents or grandparents. Increased sex education in schools, increased parental efforts to provide factual information, and a rise in the amount and explicitness of sex in the media are the main reasons for early exposure.

One of the root causes of teenage pregnancy is the lack of future plans and aspirations, especially for low-income and minority girls. Adolescents with higher education and career goals are less likely to become pregnant than their classmates or peers with less clear life ambitions. Surveys have confirmed time after time that future-thinking adolescents have been encouraged, primarily by their parents, to set high achievement and educational goals.

Another important factor in teen pregnancy is the normal development sequence. Adolescents often reach reproductive maturity before they have the communication and interpersonal skills necessary to control physical intimacy. A loving, accepting, supportive family environment where parents acknowledge their children's sexuality and convey a positive attitude about sex fosters the development of sexual attitudes that allow adolescents to make their own sexual decisions. Teens in these households tend to have set goals and delay pregnancy longer.

Teens at Risk

Adolescents who grow up in a high risk environment are eight times more likely to become pregnant than other teenagers. High risk factors include:

- growing up in a single-parent family
- being a victim of past sexual abuse
- having five or more siblings
- having a sister or friends who became teenage mothers
- living in a female-headed household
- being a member of an ethnic minority or low-income group
- living in a low income neighborhood
- lax parental control of dating and free time
- dropping out or failing in school

Adolescents who grow up in a female-headed household or who have sisters or friends who are teenage mothers will be more likely to see pregnancy and motherhood as an acceptable way to achieve adult status. Independence within the family and community are often established by becoming pregnant. For other teens, having a baby gives them someone to care for and to love. This may fulfill needs not being fulfilled within the family. African-American girls are especially at risk of becoming pregnant because they are more likely to begin having intercourse at an earlier age. Contraceptive use is particularly low for younger teens.

What Can I Do as a Parent?

There are four broad areas where parents and teens can work together to reduce the risk of pregnancy: Interpersonal communication, accurate information, problem-solving skills, and education and future plans.

Interpersonal Communication. Problems in parent-child communication may increase the likelihood that the adolescent will engage in sexual activity. Adolescents respond to warmth and affection, and they need to feel accepted by family and friends. Parents can help their children by:

- planning regular and frequent time to talk
- routinely discussing sexual issues; once is often not enough for learning to occur
- defining clear roles within the family
- making a real effort to understand each other's perspective
- consistently enforcing rules that have been mutually negotiated and agreed upon
- developing a clear value system that favors postponing sexual intercourse
- helping teens identify and express their feelings, attitudes, and values in nonsexual ways
- providing a confidential diary or journal to encourage teenage girls to express emotions, disappointments, or aspirations, and to think matters through before becoming sexually active

Accurate Information. Although sex education alone is not enough to prevent teenage pregnancy, it is critical for teens to have accurate information about sex and contraception:

- provide teens with accurate facts about physical development, reproduction, and contraception
- make teens aware of the income needed to support a child and family
- inform teens of the difficulties and responsibilities of pregnancy and childrearing, including economic, social, and emotional costs
- have regular and frequent talks about sexual issues beginning at about age 8, increasing frequency with maturity
- initiate discussions to find out what children know and want to know
- handle child/teen initiated discussions thoroughly, seriously, and with respect
- if you do not know the answer to a question, look for the answer together

Problem-solving Skills. Adolescents who do not have good problem-solving skills often make poor decisions. A teenager may engage in early sexual activity before thinking about protection, alternatives, or consequences. Children must be taught and continually encouraged to use problem-solving skills:

- teach children to think of several solutions to a problem and predict possible results before selecting a solution
- allow the child to be responsible for finding the solution with minimal parental help and without severe criticism
- teach children to determine whether a solution is satisfactory or not and to think of ways to improve the outcome
- guide children through the process of actively seeking information and answers from community and family sources

Education and Future Plans. Teens who become pregnant tend to have a history of low academic achievement. They live predominantly in the present with a limited view of the future. Help children look to the future by:

- encouraging high academic achievement
- helping teenagers explore potential careers and salaries
- pointing out the link between education and economic success
- monitoring homework and grades
- seeking help for academic difficulties immediately
- communicating regularly with teachers and the school
- helping teens develop personal and long-term goals
- encouraging outside activities and friendships based on identified interests

It is quite normal to feel uncomfortable talking with your child about sex. However, it is also too important an issue not to discuss. Even if you have never talked to your children about sexual issues, start now. Children look to their parents to guide their behavior and counteract the media's distorted view of sexual relationships. Helping teens understand and deal with questions about values, ethics, love, relationships, feelings, and emotions encourages mutual honesty, respect, and trust.

Resources

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by Doris Wright, Ph.D.
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Biracial Children

Practical Suggestions for Parents and Teachers

Diverse Cultures and Lifestyles

Overview

Over the past ten years American schools have witnessed an amazing growth of biracial children from different racial and ethnic groups. These biracial children force America's teachers, counselors and school psychologists to wonder how best to maximize their education. This handout provides parents and teachers practical suggestions to help these biracial children succeed in school and in life.

There is no consensus as to what is meant by the term *biracial.* In general, it is most commonly used to describe the first generation offspring of parents from different races. It can be used to describe children of Black and White, Latino and White or Asian and White parents just to name a few. In some instances, it could be used to describe the children whose grandparents are from different races, also. The term, *biracial,* will be used here to characterize all children born to parents from different racial groups or possessing different racial heritages. The phrase, *Biracial child,* is preferred to such names as "mixed race" or interracial child.

Myths About Biracial Children

What is important to know about biracial children? School professionals and parents alike must recognize and challenge the myths that surround biracial children. Researchers Kerwin and Ponterotto (1995) mention three myths that are particularly detrimental to biracial children.

Myth 1: Biracial children are "tragic mulattos" or are seen as "marginal persons." All too often, school personnel — and even parents — buy into the notion that biracial children will have long lasting problems as a result of their racial heritage. The biracial child should be viewed as having a "double rich heritage." Destroying this myth is necessary in order to preserve the child's positive belief in oneself and in one's family of origin.

Myth 2: Biracial individuals must choose to identify with only one group. This myth suggests whenever a biracial child has a White parent and another parent of color, the child is forced to adopt the racial identity of the parent of color because society will see the child in that way. This myth is a dangerous one for a developing child because it harms a child's sense of self and esteem.

Myth 3: Biracial persons don't want to talk about their racial identity. This naive perception is one often expressed by well meaning teachers, counselors and school psychologists who believe they are protecting the child. These school professionals are afraid (or unwilling) to discuss racial heritage or racial identity with either the children or their parents. Failing to ask children about their racial heritage is counterproductive to learning. Moreover, as researchers discovered, biracial children really do not mind discussing their racial heritage if such inquiries are open and nonjudgmental.

Suggestions for Parents of Biracial Children

The above myths neither help nor support biracial children to grow and become successful in school. If parents and teachers are to overcome these myths, what should they do to help biracial children?

1. ***Understand that your children's racial heritage cannot be separated from their total growth or development.*** Racial identity develops early, often as young as age three. Teach your children early *all* about their double rich heritage and use language they can understand.
2. ***Teach children the racial customs, traditions and cultural practices of both parents or extended families.*** Respect the religious customs of each parent's racial group, also.
3. ***Consider how decisions about choice of school or neighborhood affect your child's biracial identity development.*** Select schools and neighborhoods that reflect the double rich heritage of your children.
4. ***Don't freak out if your child begins to identify with one racial group.*** This immersion into one parent's racial group is an important part of your children's development. It is not always harmful. Continue to educate your children about their racial heritage from both parents even if the child shows little interest at the moment.
5. ***Don't be colorblind!*** Help your children understand that other children and even teachers say hurtful things about their racial heritage. Teach children to develop nonviolent ways to handle these insults so that their self esteem and sense of worth are not damaged.
6. ***Expect biracial teenagers to face special challenges during adolescence.*** Peer pressure and peer prejudices can be harmful to biracial teens. Such destructive peer pressures can be negated through their participation in sports, band, clubs and other activities that do not place significance solely on race.
7. ***Teach late adolescent and early adult biracial individuals how to preserve their double rich heritage in college or at work.*** Young adults begin to immerse themselves in one cultural group to the exclusion of the other one. Help these young adults to continue valuing their double rich heritage while intensely exploring the cultural group of one parent.

Recommendations to Teachers and Other School Personnel

1. ***Color blindness to a child's racial heritage impedes learning.*** Do not ignore the importance of a learner's racial background as you design classroom activities. Remember children learn within a racial and cultural context.
2. ***Ask children about their racial background.*** It is okay to ask biracial children about their "double rich heritage." It must be done in an open an nonjudgmental manner. Ask parents to tell you what racial labels or descriptions are most appropriate for your child.
3. ***Consult with experts about appropriate interventions for working with biracial children.*** Most teachers received no formal training in college concerning biracial children. Ignorance is no excuse when it comes to educating biracial children. Consult your principal, other school personnel or community leaders to help you understand these children.
4. ***Never permit any racially harmful language or actions to occur within your own classroom.*** Remaining silent whenever hurtful comments are made about biracial children amounts to colluding with the oppressor. Teach children early about the harmful effects of racial slurs. Correct your students whenever you hear such language. Work with your principal to eradicate all professional practices and teacher language that harms biracial children, too. Do not tolerate such language in teachers' lounges, either.
5. ***It is not your role to assign a racial designation to a child.*** Never tell biracial children what you believe to be their racial group or racial heritage. If you do comment, you could be supporting a racial stereotype. Discuss your concerns with parents. Accept whatever racial designation parents tell you.

6. ***Understand how racial heritage is related to a biracial child's sense of self and esteem.*** Be sure that your classroom activities and your comments all work together to promote the "double rich heritage" of biracial children.

7. ***Become an advocate for biracial children.*** Speak out on behalf of biracial children if you see professional practices or school customs that you believe are detrimental to biracial children and also to children of color. Work to develop curricula that supports biracial identity development.

Summary

This handout offers several suggestions to teachers and parents alike for the purpose of supporting biracial children at all ages. These suggestions do not require advanced degrees or sophisticated understanding. All that is required is a respect for individual differences and an appreciation for the richness that children from dual cultures can create. Teachers and parents must expand their partnerships in order to create innovative and racially supportive classroom and family interventions for biracial children. Together, they can develop effective learning resources to help biracial children excel and achieve.

Resources

Funderberg, L. (1994). *Black, white, other: Biracial Americans talk about race and identity.* New York: William Morrow & Co.

Gay, K. (1995). *I am who I am: Speaking out about multi-racial identity.* New York: Franklin Watts.

Kerwin, C. & Ponterotto, J. (1995). Biracial identity development: Theory and research. In Ponterotto, J., Casas, M., Suzuki, L. & Alexander, C. (Eds.), *Handbook of multicultural counseling.* Thousand Oaks, CA: Sage.

Root, M. P.P. (1997). Biracial identity. In G. Bear, K. Minke, & A. Thomas (Eds.), *Children's needs II: Development, problems and alternatives.* (pp. 751-760). Bethesda, MD: National Association of School Psychologists.

Root, M P.P. (1992). *Racially mixed people in America.* Newbury Park, CA: Sage.

Wardle, F. (1987). Are you sensitive to interracial children's special identity needs? *Young Children, 42* (2), 53-59.

NATIONAL
ASSOCIATION OF
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PSYCHOLOGISTS

Gay, Lesbian and Bisexual Parents

Resources for Families

Compiled by Cynthia Asprodites, Ph.D.
Alameda (CA) Unified School District

Print Media

Benkov, L. (1994). *Reinventing the family: The emerging story of lesbian and gay parents.* New York: Crown.

Clay, J. (1990). Working with lesbian and gay parents and their children. *Young Children*, 45 (3). New York: NAEYC.

Gay and Lesbian Parents Coalition International. (1991). *Books for children of lesbian and gay parents.* GLPCI, P. O. Box 50360, Washington, D.C. 20091; (202) 583-8029.

Gay and Lesbian Parents Coalition International. (1992). *A bibliography on gays and lesbians and their families.* GLPCI, P. O. Box 50360, Washington, D.C. 20091; (202) 583-8029.

Goodman, Jan (April, 1993). Lesbian, gay and bisexual issues in education. *Thrust for Educational Leadership.* (Publ. of ACSA, Association of California School Administrators.)

Gordon, L. (1994). What do we say when we hear "faggot"? In *Rethinking our classrooms: Teaching for equity and justice* (pp. 86-87).

Lipkin, Arthur. *A staff development manual for anti-homophobia education.* Harvard Graduate School of Education, TCLE, 210 Longfellow Hall, Cambridge, MA 02138.

Martin, A. (1993). *The lesbian and gay parenting handbook: Creating and raising our families.* New York: Harper Collins.

Steckel, A. (1987). Psychosocial development of children of lesbian mothers. In F. Bozett (Ed.), *Gay and lesbian parents* (pp. 75-85). New York: Praeger.

Wolf, S. F. (1994). *The children of lesbians and gay men in public primary classrooms.* Unpublished master's thesis. University of California-Berkeley.

Making schools safe for gay and lesbian youth: Breaking the silence in schools and in families. Education Report. Governor's Commission on Gay and Lesbian Youth. State House, Room 116, Boston, MA 01133; (617) 828-3039.

Videos

Both my moms' names are Judy. Lesbian and Gay Parents Association, 6705 California St. #1, San Francisco, CA 94121; (415) 387-9886.

It's elementary: Talking about gay issues in school. Women's Educational Media, 2180 Bryant St. #203, San Francisco, CA 94110; (415) 641-4616.

Organizations

National Education Association (NEA): 201 16th St. NW, Washington, D.C. 20036; (202) 822-7700. *The NEA has developed a training program for educators about the needs of gay youth.*

Lesbian, Gay and Bisexual Issues in Education: An ASCD Network, P.O. Box 15043, Ann Arbor, MI 48108. *The ASCD Network for Lesbian, Gay and Bisexual Issues in Education, established in the fall of 1992, is an alliance of heterosexual and lesbian/gay/bisexual educators who work to assure that ALL members of the school community receive fair and equitable treatment in an environment where it is safe to be themselves. Join the Network ($10) and receive periodic newsletters and a newly published 26-page resource directory.*

Equity Institute: 6400 Hollis St. Suite 15, Emeryville, CA 94608 (510) 658-4577. *Equity Institute is an internationally recognized consulting agency that assists organizations in becoming fully multicultural. Equity's projects includes* Sticks, Stones, and Stereotypes, *a highly acclaimed video documentary curriculum module designed especially for high school students. The module focuses on homophobic, racial, ethnic and anti-Jewish slurs, the anguish caused by such remarks, the reasons people participate in name-calling, and what can be done to stop it.*

Lesbian and Gay Parents Association: 6705 California St. #1, San Francisco, CA 94121 (415) 387-9886. *This is an organization which offers workshops to Bay Area schools on overcoming homophobia in the elementary school classroom. They have produced a 10-minute video,* Both My Moms' Names are Judy, *interviews with school-aged children in gay and lesbian families.*

COLAGE (Children of Lesbians and Gays Everywhere): 2300 Market St. #165, San Francisco, CA 94114; (415) 861-KIDS. *This organization issues a newsletter and organizes social activities and support groups for Bay Area school-aged children and youth.*

Gay and Lesbian Alliance Against Defamation (GLAAD): P. O. Box 931763, Hollywood, CA 90093; (213) 463-3632. *GLAAD has developed a curriculum to help teach students about homophobia.*

Project 10: c/o Virginia Uribe, Fairfax High School, 7850 Melrose Ave., Los Angeles, CA 90046; (213) 651-5200 or (818) 441-3382. *Project 10, begun in 1984 in the LA Unified School District as the first on-campus gay-affirmative counseling program for gay youth, has become a model program for other school districts. The program conducts workshops for administrators and staff and has developed the Project 10 Handbook, a resource directory for educators. A curriculum for teaching about gay, lesbian, and bisexual youth is available in Spanish and English.*

Project of the Study of Gay and Lesbian Issues in Schools. Dr. Arthur Lipkin, Harvard Graduate School of Education, 210 Longfellow Hall, Cambridge, MA 02138; (617) 491-5301. *Support Services for Gay, Lesbian, & Bisexual Youth, San Francisco Unified School District, Kevin Gogin, 1512 Golden Gate Ave., San Francisco, CA 94115; (415) 749-3400.*

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Gay, Lesbian and Bisexual Students and Families

Creating a Supportive School

by Cynthia Asprodites, Ph.D.
Alameda (CA) Unified School District

Personal and Staff Development

- Examine your own attitudes and beliefs about homosexuality. Become informed about issues related to sexuality by reading and attending lectures and workshops.
- Should personal prejudices and/or religious beliefs about homosexuality be in conflict with professional expectations, those attitudes must be set aside or overcome in order to assure equity for all students.
- Engage in formal staff development activities to obtain accurate information about homosexuality and to address the cognitive, affective, and behavioral dimensions of homophobia. Encourage honest dialogue about the issues.

School-Wide Policy and Practice

- Realize the moral imperative to create a safe place for the children in your school.
- Be aware of your own biases, assumptions: do not assume that all parents, all other educators, and all youth are heterosexual. Confront misinformation and stereotypes.
- Represent family/cultural diversity in classroom materials, on bulletin boards, and in everyday teaching practice.
- Review school materials for biased or misleading information about lesbians and gay men.
- When establishing parent-teacher associations, make reference to the diversity in family structures within the school community, and encourage gay and lesbian parents to share with school administrators their status.
- Prepare school staff to work with children as well as their parents as they confront issues ranging from the child's need for self-protection to the parent's need for respect.
- Hold a series of informal meetings with gay and lesbian parents and faculty to identify needs and possible solutions. Invite former students and community members who identify as gay, lesbian or bisexual to address the school staff about their experiences and perspectives.
- Review and revise accordingly student and faculty school-sanctioned activities which discriminate on the basis of sexual orientation (e.g., school dances, staff parties, job recruitment fairs).
- Include sexual orientation inthe non-discrimination language of school policies applying to students, faculty, staff.
- Modify school's anti-slur policy to include sexual orientation and equally enforce violations against this policy.
- Redesign school paperwork to be inclusive. Replace words such as "mother" and "father" with "parents" (parent 1, parent 2) or "caregivers" on necessary forms (e.g., school registration, emergency forms, lunch applications, assessment plans).

Classroom Interventions for Teachers

- Include literature which portrays gay and lesbian characters in your classroom library and curriculum materials.
- Be conscious of the implicit heterosexist bias in certain classroom activities (e.g., family tree). Make modifications in such activities so that *all* children can participate.
- Engage (younger) students in class discussions about what makes a family.
- Present positive images of gay and lesbian people in the classroom.
- Provide age-appropriate lessons that include gay and lesbian issues: introduce vocabulary, look for teachable moments, use current events, acknowledge that authors, historical figures and other famous people who come up in class discussions are gay, lesbian, and bisexual, include gay rights in discussion of social justice concerns, celebrate holidays,
- Respond openly and directly to any anti-gay incidents (e.g., verbal assaults) or discriminatory actions. Interrupt such incidents and confront the underlying assumption that "being gay is bad".
- Discuss name-calling and other ways that homophobia is manifested, why such incidents will not be tolerated, and suggest ways for students to interrupt anti-gay name-calling.
- Be prepared to speak with your administrator about the nature of any class discussion relevant to gay/lebian families. Be prepared to talk with unsupportive parents.

Suggestions for Working with Gay and Lesbian Parents

- Talk with parents about ways to create a supportive environment for their children and how they would like you to handle specific questions from other students in the classroom.
- Listen to parents' concerns and fears about prejudice their children may face at school.
- If unsure about the nature of the parents' relationship and how they would like to be addressed, ask how they would like to be addressed and how the child refers to them each.
- Respect parents' choices to either disclose or maintain secrecy about the nature of their sexuality and understand the derivation of their decisions.
- Welcome *both* parents at all times. Recognize the non-biological parent as legitimate.
- Be aware of the heterosexist bias in language in forms, letters home, etc.
- Inform parents of any incident of sexual harassment or intimidation directed at their child.
- Hold a series of informal meetings with gay and lesbian parents and faculty to identify needs and possible solutions.
- Do not link the psychological problems of children to the parents' sexual orientation or the nature of their relationships.
- Provide resource information to parents who may be in the process of coming out, or those who express feelings of isolation and seek support.
- Some students have parents, siblings, or other relatives or family friends who are gay or lesbian. Many may discover that they themselves are gay or lesbian.

Resources

Bass, E. & Kaufman, K. (1996). *Free Your Mind: The Book for Gay, Lesbian, and Bisexual Youth and Their Allies.* New York: Harper.

Besner, H. & Spungin, C. (Eds.) (1995, 1996). *Gay and Lesbian Students: Understanding Their Needs/Training for Professionals who Work with Gay and Lesbian Youth.* Briston, PA: Taylor & Francis

Pollack, Jill S. (1995). *Lesbian and Gay Families.* New York: Watts.

Video

It's Elementary: Talking about Gay Issues in School. Women's Educational Media, 2180 Bryant St. #203, San Francisco, CA 94110; (415) 641-4616.

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Gay Families with Children

Information for Educators

by Cynthia Asprodites, Ph.D.
Alameda (CA) Unified School District

Background

As we consider the increasing diversity of our student population, the topic of children with lesbian and gay parents is typically neglected. Their families tend to be rendered invisible in the culture and consciousness of our schools by societal prejudice. If our schools are to serve *all* students, then it is imperative that educators become aware of issues relevant to lesbian and gay parents and their children and develop strategies for addressing their needs within the context of the school setting.

Gay Families: It is estimated that, in the U. S., there are 1 to 5 million lesbian mothers, 1 to 3 million gay fathers, and 6 to 14 million children with gay or lesbian parents. Like families headed by heterosexual parents, lesbian and gay parents and their children are a diverse group. Many children with gay or lesbian parents were born in the context of heterosexual relationships, typically a prior marriage that dissolves when the father "comes out" as gay and/or when the mother "comes out" as a lesbian. There are also increasing numbers of lesbians and gay men, both single and coupled, who are choosing to become parents. Many lesbians become pregnant through donor insemination, using sperm from either known or unknown donors. Legal adoption, permissable in many states, is another venue. Parenting options pursued by gay men include adoption, donor insemination with the intention of co-parenting with the child's mother, and surrogacy with the intention of raising a child singly or with a gay male partner. While the term "gay family" is no more definitive than "American family", what is common to all gay families is the vulnerability to prejudice and discrimination based on sexual orientation and supported by cultural, legal and judicial sanctions.

Summary of Research: Research on lesbian and gay parents and their children is in an emergent stage. The available empirical data dispel false assumptions about gay and lesbian parents relative to their psychological adjustment and parenting skills, the effect of disclosure of their sexuality to their children, and their influence on the sexual orientation and psychological adjustment of their children. The research findings are clear: there is *no* evidence to suggest that the psychosocial development of children raised by lesbian and gay parents, relative to their peers raised by heterosexual parents, is compromised in any respect. These children are, however, more likely to experience harassment in school because of societal judgments about their parents' sexual orientation. Thus, the difficulties of growing up in a lesbian or gay household are linked not to the nature of parents' relationships, but rather to the homophobia and heterosexism pervasive in our society and tolerated in our schools. A number of specific findings are offered by the accumulating research:

- Children of a lesbian or gay parent are no more likely to define themselves as homosexual than children of heterosexual parents, nor are they any more likely to display sex role preferences. Children of a lesbian or gay parent follow typical developmental patterns of acquiring sex role concepts and sex-typed behaviors.
- Children of gay parents who have experienced marital turmoil face similar difficulties common to children of divorce.
- As children enter adolescence, there is a greater likelihood that they will experience peer harassment about their parents' sexual identity and engage in a variety of self-protective mechanisms.

- There are indications that children find it easier to deal with issues raised by having lesbian and gay parents if they learn of parental sexual orientation during childhood rather than in adolescence.
- Existing data suggest the value of a supportive milieu in which parental sexual orientation is accepted by other significant adults, and in which children have contact with peers in similar circumstances.

Challenges Facing Children with Gay Parents: School is typically the first place that children become aware of the societal prejudice against their parents: they hear the insults that describe their mothers and fathers on the schoolyard. The most common challenge confronting children raised by lesbian and gay parents involves fear of rejection and harrassment and coping with feelings of isolation. This is particularly true during adolescence when children are likely to fear that others may assume that they, too, are homosexual. The invisibility of gay and lesbian parents supports a climate of silence for children as well, making knowledge about other children inaccessible. Children often report the sentiment, "There's no one else like me."

Relevant to the school setting, the psychosocial needs of children from gay and lesbian families primarily involve issues of inclusion and safety. Children need to feel included, to have their families recognized and their personal experiences validated, as reflected in the language of the classroom and the culture of the school. They also need to feel safe from harassment and discrimination in the school setting. This is, of course, true for all children in our schools, though the needs of children in gay families, analogous to children from other marginalized groups, are underscored by a climate of social intolerance.

Strategies for Responding to the Needs of Children with Gay Parents

By responding to the needs of children raised in gay families, educators can create inclusive and safe environments for all children. Strategies to achieve this goal include countering misconceptions about homosexuality with accurate information, challenging practices which sanction the invisibility of gay members of the school community, and recognizing and confronting incidents of intolerance and harrassment without equivocation. A number of general recommendations are discussed below with a listing of specific interventions at the end of this resource guide.

Personal and Professional Development: A first step toward being responsive to the needs of children in gay families is a personal commitment to examine one's own attitudes and beliefs about homosexuality. Become informed about issues related to sexual orientation by reading and attending lectures and workshops. Accurate information is essential in dispelling false assumptions and misconceptions. It is important to state that, should personal prejudices and/or religious beliefs about homosexuality be in conflict with professional expectations, those attitudes must be set aside or overcome in order to assure equity for all students. It can be argued that educators have a moral responsibility to make school safe for all students and to teach students to be critical of all forms of oppression.

Working with Families and Children: It is very important for educators to communicate understanding and acceptance in meeting with parents. If parents are seeking consultation, issues of oppression of sexual minorities and concerns about their children may be central mental health concerns necessitating some affirmative response from the teacher or administrator. If parents are seeking consultation about the learning or social/emotional needs of their child, be cautious not to attribute the child's presenting problem to the parent's sexual orientation.

Gay and lesbian parents consciously assess psychological safety and the possible negative consequences of disclosure about their sexuality. Be conscious that race, religion, culture, and socioeconomic status are influential factors in parents' decisions to disclose. Should parents disclose the nature of their relationship, then issues of confidentiality should be discussed. Because the process of coming out and assuming a gay or lesbian identity is frequently a disruptive experience in a parent's life, parents may share feelings of isolation and seek information about gay and lesbian parent support groups.

It is also important to keep in mind that some children are faced with a parent struggling with AIDS and that dealing with societal prejudice around homosexuality is compounded by ignorance about AIDS. Working with families around these issues demands sensitivity and requires that teachers and administrators become well-informed about AIDS.

Development of Equitable School-wide Policies and Practices: A microcosm of society, schools mirror society's prejudices as well as its values. A critical first step in combatting the manifestations of homophobia to recognize and interrupt incidents of intolerance and harrassment. Because homosexuality is such as charged issue, teachers are often reluctant to confront children who engage in anti-gay name-calling to intimidate other children. Homophobic remarks should be as unacceptable as any racial or ethnic slur. Misinformation and stereotypes must also be confronted. Educators can model how to respond to anti-gay incidents and verbal assaults whenever they occur, including insensitive remarks by a colleague or parent. Administrators can encourage honest discussion of anti-gay bias and explore ways to make their schools safe and more inclusive of all children and their families. School psychologists can provide resource materials and serve as a referral source for school staff and parents by providing names of gay community agencies or individual mental health service providers who are gay sensitive.

Educators should encourage the development of equitable school-wide policies. For example, they can encourage schools to set up clear guidelines for behavior which includes name-calling based on race, gender, ethnicity, religion, and sexual orientation, etc. and enforce consequences for violation of these norms. Sexual orientation can be included in the non-discrimination language of school policies applying to students, faculty, and staff. Heterosexist bias in language and policies including forms should be eliminated.

Curriculum Development: The philosophy that supports the inclusion of multicultural perspectives throughout the curriculum applies to gay and lesbian issues as well. We should encourage inclusion of formal and informal education about non-traditional families into the curriculum, including gay and lesbian families. The issue is visibility: to remain silent is a form of collusion in the oppression of lesbians and gay men in the culture of the school. When teachers present age-appropriate materials that remove the stigma attached to lesbians and gay men, the incidence of homophobic slurs is likely to decrease. Educators need to feel comfortable using the language, saying words like "lesbian" and "gay". Talking about gay and lesbian families in the classroom means recognizing the existence of a family structure which reflects the reality of some of our students. In talking about different kinds of families, children learn about diversity, tolerance, and respect for differences.

Note

Homophobia is defined as fear or hatred of same-sex closeness.

Heterosexism is defined as the assumption that everyone is, or should be, heterosexual. It is the belief that heterosexuality is a superior way to live and love. In most countries, heterosexism is supported by the legal and judicial systems. Homophobia and heterosexism do not exist in a vacuum, separate from other forms of oppression in this society. All the *-isms*, that is, racism, sexism, classism, anti-Semitism, and heterosexism, are connected, linked by the existence of power imbalances, by a pervasive system of exclusion based on group identity.

Resources

Benkov, L. (1994). *Reinventing the family: The emerging story of lesbian and gay parents.* New York: Crown Publishers.

Clay, J. (1990). Working with lesbian and gay parents and their children. *Young Children*, 45 (3). New York: NAEYC.

Gay and Lesbian Parents Coalition International (1991). *Books for children of lesbian and gay parents.* GLPCI, P.O. BOX 50360, Washington, D.C. 20091; (202) 583-8029.

Gay and Lesbian Parents Coalition International (1992). *A bibiography on gays and lesbians and their families.* GLPCI, P.O. BOX 50360, Washington, D.C. 20091; (202) 583-8029.

Gordon, L. (1994). What do we say when we hear "faggot"? In *Rethinking our Classrooms: Teaching for Equity and Justice* (pp. 86-87).

Martin, A. (1993). *The Lesbian and gay parenting handbook: Creating and raising our families.* New York: Harper Collins Publ.

Patterson, C. (1992). Children of gay and lesbian parents. *Child Development*, 63, 1025-1042.

Patterson, C. (1995). *Lesbian and gay parenting research review.* APA Public Interest Directorate, Washington, D. C.

Sears, James T. (1994). Challenges for educators: Lesbian, gay, and bisexual families. *High School Journal,* 77 (1 & 2), 138-156.

Victor, S. & Fish, M. (1995). Lesbian mothers and their children: A review for school psychologists. *School Psychology Review, 24* , 456-479.

Videos

Both My Moms' Names' are Judy. Lesbian and Gay Parents Association, 6705 California St. #1, San Francisco, CA 94121; (415) 387-9886.

It's Elementary: Talking About Gay Issues in School, Women's Educational Media, 2180 Bryant St. #203, San Francisco, CA 94110; (415) 641-4616.

Organizations

GLSTN (Gay, Lesbian, Straight Teachers Network), Box 390526, Cambridge, MA 02139. *GLSTN is a national organization that brings together gay and straight educators working to end homphobia in our schools.*

Lesbian, Gay and Bisexual Issues in Education: An ASCD Network, P. O. Box 15043, Ann Arbor, MI 48108.

Lesbian and Gay Parents Association: 6705 California St. #1, San Francisco, CA 94121; (415) 387-9886.

COLAGE (Children of Lesbians and Gays Everywhere): 2300 Market St. #165, San Francisco, CA 94114; (415) 861-KIDS *This organization issues a newsletter and organizes social activities and support groups for Bay Area school-aged children and youth.*

Gay and Lesbian Alliance Against Defamation (GLAAD): P. O. Box 931763, Hollywood, CA 90093; (213) 463-3632. *GLAAD has developed a curriculum to help teach students about homophobia.*

Project of the Study of Gay and Lesbian Issues in Schools. Dr. Arthur Lipkin, Harvard Graduate School of Education, 210 Longfellow Hall, Cambridge, MA 02138; (617) 491-5301.

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Gay/Lesbian/Bisexual Issues Bibliography

A Bibliography for School Personnel

Edited by Mary Henning-Stout, Ph.D., NCSP and Steve James, Ph.D.
NASP Committee on Gay, Lesbian and Bisexual Issues

Introduction

The following reviews were submitted by school and other psychologists of 18 resources, from reference books to novels to videos to Internet. Each entry begins with the title of the resource and bibliographic information. This information is followed by the name of the reviewer, her or his judgment of the appropriate audience for the resource and synopsis of its contents. It is our hope that this material will be of immediate use, and that this bibliography will be useful to school personnel working with lesbian, gay, bisexual, transgender and questioning youth.

Books

Heron, Ann (Ed.) (1995). *Two Teenagers in Twenty*. Boston: Alyson Publications.

Reviewer: Helen Lovallo, NCSP

Appropriate Audience: Young people wondering whether or not they are homosexual or bisexual; their friends and families; high school and public libraries; school counselors, school psychologists, administrators and teachers working with teens; clergy and health professionals; people of any age who are coming out as gay.

Synopsis: According to Ann Heron, approximately one teenager in ten is gay, lesbian or bisexual. Each has an individual way of deciding whether or not the label gay applies, whom to tell and how to deal with the various strong feelings involved. This book describes the coming-out process, as written by twenty-eight young people, ages fifteen to twenty-four. The authors describe how they became aware of their sexual orientations as gay or lesbian, and how they dealt with the confusion which followed that awareness. Their stories relate the ongoing process of coming out to friends and family, and they offer advice on whom to tell and when. The writings range from love stories to horror stories about rejection to intellectual and religious musings. Interwoven throughout the book is the repeated and depressing discovery of how little help is available for these young people in their families, schools, churches and communities. Many authors describe the necessity of working out their problems in isolation. The book includes a list of references for support in coming out, a Gay Teen Pen Pal organization and a list of other books of interest. The book is strong in the variety of experiences portrayed, but its list of resources is outdated.

Pollack, Jill S. (1995). *Lesbian and Gay Families*. New York: Watts.

Reviewer: Helen Lovallo, NCSP

Appropriate Audience: All school counselors, school psychologists, teachers and administrators; gay teens and their families; gay adults; high school and public libraries; clergy and health professionals.

Synopsis: This book has as its thesis the following: It is not a particular family formation, but love which makes a family. Actually, the book covers much more. It discusses the history of gay rights and gay parenting in America, defines homosexuality and describes various methods of family formation. It offers an excellent discussion of the coming-out process, and describes how to create alternative family in the wider culture. The book features an extensive list of support groups nationwide and in Canada, Internet resources and a bibliography of books regarding gay history and parenting. The book covers its subject thoroughly. Its main limitation is that it is so obviously pro-gay that it may not persuade a doubting or anti-gay individual that gays, lesbians and bisexuals can be good parents.

Romesburg, Don (Ed.) (1995). ***Young, Gay, and Proud, 4th ed.***
Boston: Alyson Publications.

Reviewer: Dawn A. Mahtar

Appropriate Audience: Gay, lesbian or bisexual adolescents, or those who are questioning their sexual orientation. Also appropriate for young adults or anyone interested in learning more about the experiences of gay, lesbian and bisexual youth.

Synopsis: Young, Gay, and Proud is written primarily by gay, lesbian and bisexual adolescents. Much of the information in the book is presented through anecdotes from the authors' own experiences with realizing and acknowledging their sexual orientation, coming out, dealing with others' reactions and other issues. Safe sex and health issues are also covered and a list of resources is provided. The book also lists notable gay men, lesbians and bisexuals from the present and past. There are two notes of caution regarding this book: First, many of the authors provide advice on various issues. Readers must take this advice in the context of their own situation and seek out other resources as necessary. Most of the authors are not professionals — they are simply youth who are sharing from their own experience. While this experience is extremely valuable, it is important to remember that everyone's experience is different. Second, the book contains two fairly explicit chapters on sexuality, one for lesbians and one for gay men. Keep this in mind when recommending this book to anyone who may be turned off to more important issues by the inclusion of sexually explicit material.

Bass, E. & Kaufman, K. (1996). ***Free Your Mind: The Book for Gay, Lesbian, and Bisexual Youth and Their Allies.*** **New York: Harper.**

Reviewer: Dawn A. Mahtar

Appropriate Audience: Primarily for gay, lesbian and bisexual youth; however, it also includes chapters that are written specifically for parents, educators, religious leaders and congregations, community service providers, and gay, lesbian and bisexual adults.

Synopsis: Free Your Mind includes a basic exploration of what it means to be gay, lesbian or bisexual, as well as discussions of homophobia and ethnic diversity within the gay community. Later chapters cover aspects of daily life, including relationships with peers and family, religion, and school and community situations. Throughout the book, the authors have provided quotes from many gay, lesbian and bisexual youth, as well as their parents. They have also included brief sketches of current and past gay, lesbian and bisexual public figures from politics, literature, the arts and other areas. The authors also provide an extensive list of resources including books, pamphlets, videos, online services and addresses for many support groups and agencies. While the book is somewhat lengthy, it is designed so that the reader can choose sections to which to refer without having to read the entire book. Information that is relevant to a number of different audiences is presented in-full only once; readers of other chapters are then referred to the pages where the information appears. This format enhances the usefulness of the book as a reference tool, but it may discourage some readers from reading chapters addressed to other populations. This is unfortunate, because the entire book contains useful information.

Hutchins, L. & Kaahumanu, L. (Eds.) (1991).
***Bi Any Other Name: Bisexual People Speak Out*. Boston: Alyson Publications.**

Reviewer: Denise DeZolt

Appropriate Audience: Older adolescents, parents, school psychologists, psychologists, other mental health professionals, educators.

Synopsis: Hutchins and Kaahumanu, two bisexual women, have edited this anthology written by and about bisexual people. The diverse array of contributing authors speak in their own voices through prose, poetry and interviews about their experiences across psychological, spiritual, community and political domains. The reader is able to explore the dilemmas and challenges faced by bisexual individuals as they encounter themselves, their loved ones, the heterosexual and gay and lesbian communities. The writings give greater understanding of the common issues, myths and realities faced by bisexual individuals and their idiosyncratic journeys. Each section begins with an overview of the major theme of the section followed by often poignant, sometimes sexually explicit, sometimes humorous, sometimes highly critical real-world experiences of the contributing authors.

Besner, H. & Spungin, C. (Eds.) (1995, 1996). *Gay and Lesbian Students: Understanding Their Needs/Training for Professionals Who Work with Gay and Lesbian Youth.* Briston, PA: Taylor & Francis.

Reviewer: Sheri DeMott

Appropriate Audience: Any professional or para-professional currently working or likely to be working with gay and lesbian students in an educational or other setting, including school psychologists, school nurses, teachers, counselors, deans, administrators and support staff.

Synopsis: As the prevalence of gay and lesbian students becomes more obvious, it becomes critical for the professionals and support staff working with these students to develop functional awareness of the issues associated with sexual orientation. These two books have been designed to provide information to support the development of atmospheres of safety within schools, thereby encouraging students to come forward with their issues. The first book includes specific curriculum suggestions and research data focused practically on ways for responding to this silent and critically at-risk population. The information presented in *Gay and Lesbian Students* is tailored for use by service providers in schools, and with it the authors have developed an excellent reference guide that both promotes understanding and dispels myths concerning gay and lesbian teens. The second book, *Training for Professionals*, is slated for publication in late 1996, and provides a structured curriculum guide for providing training to school and community-based service providers. It is specific and sequential, incorporating goals, structure, training methods and steps for planning and evaluating workshop activities. Both resources will be of immediate use to school personnel.

Reference Guide

Hardesty, C. & Sherrill, J. (1994). *The Gay, Lesbian, Bisexual Student Guide to Colleges, Universities, and Graduate Schools.* New York: New York Press.

Reviewer: Sheri DeMott

Appropriate Audience: Anyone interested in ratings for specific educational facilities in terms of receptivity to gay, lesbian and bisexual people and issues. For example: school guidance counselors, high school teachers, school psychologists.

Synopsis: Based on the results of a survey that was distributed to several thousand individuals and groups nationwide, the guide supplies information on how higher educational facilities respond to gay, lesbian and bisexual students, what services are offered and what the atmosphere is for these students at the catalogued institutions. The guide provides information on almost 200 institutions and should provide valuable information for those students who wish to seek education in as non-homophobic an environment as possible.

Novels

Feinberg, Leslie (1993). *Stone Butch Blues.* Ithaca, NY: Firebrand Books.

Reviewer: Gary J. Burkholder

Appropriate Audience: Older adolescents, parents, school psychologists, psychologists, other mental health professionals, educators.

Synopsis: Stone Butch Blues is the premier work on transgender. Although it is fiction, the story is so packed with emotion and accurate representation of lesbian culture in the 1950's that it can only be the work of someone who has had that experience herself. The book covers many issues. The story follows a particular stream of culture called the lesbian experience, and it relates how the butch/femme scene played out in the bars. There are some particularly gripping accounts of police raids and the numerous sexual assaults that were perpetrated by male police officers, a vivid recall to a time when gay, lesbian, bisexual and transgender people had to wear "at least three pieces of gender-identifying clothing." Throughout the story of this cultural journey the author weaves the personal journey as well — the journey of what it is like to grow up transgender — to live a life as a "butch" lesbian. This story of a transgender woman's experience is the true heart of this novel that won Ms. Feinberg the Lambda Award for Best Lesbian Fiction in 1994. In no other work is the struggle with a transgender identity and the intense alienation and isolation it produces so clearly accessible to the reader. For anyone unsure about what it means to be "transgender," this is the book to read.

Cunningham, M. (1995). *Flesh and Blood.* New York: Simon & Schuster.

Reviewer: Denise DeZolt

Appropriate Audience: Older adolescents, parents, school psychologists, psychologists, other mental health professionals, educators.

Synopsis: Winner of the Lambda Award for Best Gay Male Fiction, Michael Cunningham weaves an intergenerational story of a contemporary American family of mixed Greek and Italian descent . In this often touching and pointed portrayal, readers are drawn to the lives of this family over three generations. With great sensitivity and sometimes brutal honesty, Cunningham explores issues and effects of family violence, incest, alcohol and other drug abuse, sexual orientation and AIDS from the multiple perspectives of the family members. A transgendered individual brings to the story and to the lives of the family members a gentle human touch and a reminder that clothes do not make the person. Sexual relationships are carefully and realistically portrayed. Imbedded in the story are bicultural and biracial considerations, the coming out process, homophobia and internalized homophobia. Perhaps the most consistent theme throughout the lives of the characters is the process, pain and promise of being in relation with oneself and with those we love. The last few chapters of the book invite the reader back time and again to experience the grief, release and freedom that comes with forgiveness and acceptance, with letting go around death and suicide.

Film/Video

***It Is What It Is.* (G. Bordowitz, director/producer; I. Velez, Jr.,writer, 1992). San Francisco: Gay Mens Health Crisis.**

Reviewer: Mary Henning-Stout, NCSP

Appropriate Audience: High school students, educators at all levels, parents, school psychologists, school counselors and social service providers wanting more insight into the interests and concerns of gay, lesbian and bisexual youth.

Synopsis: It Is What It Is is a powerful video. Part of its power lies in the direct and personal ways in which the high-school-age people in the film address a range of lesbian, gay and bisexual issues. Also powerful is the film's matter-of-fact presentation of considerations for safe sexual practice. This is important information for adolescents; in many ways it is vital. It is also information that many educators do not have — information given honest and frank presentation in this film.

***Out of My Parents' Closet: Daughters and Sons of Lesbian and Gay Parents Coming Out About Their Lives.* (Suzanne Pullen, writer/director, 1995.) SanFrancisco, CA: COLAGE and Piper Dreams Productions.**

Reviewer: Steve James

Appropriate Audience: Professionals, adults, teens and adolescents.

Synopsis: This film is an adaptation of a play by the same name first presented in 1994 by five authors who have lesbian or gay parents. Four of the five actors, not authors themselves, also have gay or lesbian parents. In exploring their relationships with their parents, these stories tell of peer relationships, the need for support in school and social settings, and the lessons of survival and compassion that the teen and young adult authors learned along their ways. The film runs nearly an hour.

***Not All Parents are Straight.* (Kevin White, director/producer, 1988.) Boston: Filmakers Collaborative (available in gay bookstores).**

Reviewer: Steve James

Appropriate Audience: All audiences.

Synopsis: This hour-long film documents the perspectives of adolescent children of gay and lesbian parents on their relationships with their parents and peers. Issues of discrimination in schools and from peers are also addressed. The kids who appear are well-spoken, humorous and poignant.

***The Incredibly True Adventure of Two Girls in Love.* (Maria Maggenti, director; Dolly Hal, producer, 1995.) Los Angeles: Fine Line Features.**

Reviewer: Denise DeZolt

Appropriate Audience: Adolescents, parents, school psychologists, psychologists, other mental health professionals, educators.

Synopsis: Maria Maggenti provides us with a touching and humorous classic coming of age story of two adolescent women who meet, fall in love, and share their first sexual experience. Issues of class, privilege, race, family and peer relationships, social support and coming out are considered as the relationship between the two young women develops. Excellent film for adolescents who are dealing with sexual orientation issues.

Internet — World Wide Web Sites

Reviewer: Philip B. Bowser, NCSP

Appropriate Audience: As indicated in each of the following summaries.

Synopsis: There was a time when information stored on the Internet was difficult to find. In the early days, researchers pretty much needed to know whose computer held what information. In response, new ways of organizing and searching for information like the World Wide Web have been developed. What follows are a few resources along with their Internet addresses as culled from a recent search. Because things change rapidly on the Web, it is possible some of these sites could disappear before this document can be published. However, when you gain access to one, you will be able to link with related sites easily from there. Once you are connected to the Internet, type one of the following addresses exactly (uppercase and lowercase usually count). There are myriad valuable resources out there on the Web, and we can be sure many of the students with whom we work are already surfing.

Oasis — Because it's a desert out there!

Address: http://www.outproud. org/oasis/

Oasis is an online magazine for lesbian, gay, bisexual, transgender and questioning youth. It provides news and entertainment written by and about homosexual youth. A typical issue will contain: profiles in courage, letters and opinions, advice columns, news and reviews, fiction and poetry, cover story (topic varies).

Soc.support.youth.gay-lesbian-bi

Address: http://www.youth.org/ssyglb/

This page explains the working of the UseNet newsgroup of the same name. The newsgroup provides a way for young people to express their feelings in a friendly forum. The newsgroup is moderated so that only appropriate postings will be distributed, thus filtering out homophobic flames and people who may be trying to take advantage of young users.

Children of Lesbians and Gays Everywhere (COLAGE)

Address: http://www.colage.org/

Resources, fun facts, and support for persons who have a gay, lesbian, bisexual or transgendered parent. (A 1987 American Bar Association study estimated here were 6-10 million youngsters in the United States eligible for membership in COLAGE.)

Resources for Parents

Address: http://www.pe.net/~bidstrup/parents.htm

Scott Bidstrup maintains this excellent page of basic, straightforward information for parents of gay youth. Topics include: What is happening to me and my child? Is it my fault? Who recruited my kid? What the Bible says about homosexuality. Can my child be cured? How can I help my child? What about AIDS? Are there some good books to read?

Lesbian Mothers Support Society

Address: http://www.lesbian.org/lesbian-moms/

This is another non-profit group. It attempts to provide peer support for biological and nonbiological lesbian parents and their children, as well as lesbians considering parenthood.

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Immigrant Parents and the School

A Handout for Teachers

by Robert Rhodes, Ph.D. and Doris Paez, Ph.D.
New Mexico State University

Background

During the past decade, more parents and children have immigrated to the United States than any other time since the turn of the century. Representing countries such as Mexico, Vietnam, China, India and the Ukraine, this fast growing and diverse group present unique challenges and opportunities for teachers. In addition to the cultural diversity and unique life experiences common to individuals entering from other countries, the vast majority of immigrant parents and children are from home countries which have a primary language other than English. This combination of cultural, experiential and linguistic diversity poses potential barriers to the integration of parents into the school environment. The following strategies are designed to provide proactive solutions to problems which may arise in the areas of home-school communication and parent involvement in school activities.

Home-School Communication Strategies

1. Provide a one-page notice to parents in their native language which emphasizes that all children have the legal right to a free public education regardless of their immigration status.
2. Post a notice at the school entrance informing parents that children do not need a green card, visa, passport or other proof of citizenship or immigration status to register for school.
3. During registration, introduce parents to school policies, procedures, grading structure, and programs in their native language. Parents who were educated in another country may not be familiar with the structure and format of the United States educational system. This introduction is best accomplished through face-to-face communication. However, if this format is not possible, a video-taped summary in the parent's native language may be created for on-site viewing or home check-out.
4. Teacher-to-parent contacts should be in the native language of the parent and should encompass all forms of home-school communication (e.g., informational letters for parents, school newsletters, picture day flyers).
5. Parent-to-teacher contacts may be facilitated by distributing "bilingual" teacher business cards (English on one side and native language of parent on other). These cards should include the teacher's name as well as the school address and phone number. Additional strategies include sending home several preprinted memo sheets with the teacher's name on top which could be dropped off at the school and placed in the teacher's box. Self-addressed, postage paid, bulk mail sheets might also be distributed to parents to be used for more lengthy communications or to notify the teacher of a change in address, etc.
6. Parent-teacher conference preparation should include consultation with individuals familiar with the parent's culture and behavioral "do's, don't's, and maybe's." Parent's should be given the option to bring their own interpreter or to have one provided by the school. They should also be encouraged to bring an extended family member or friend for support. Research also indicates the benefit of addressing the transportation and child care needs of immigrant parents as well as the need for extended time

7. At least one social/conversational meeting should be planned in order to develop an understanding of the parent's background and culture and their expectations of the school system. To minimize parent inconvenience, this informal meeting might be planned jointly with other teachers and school personnel working with the family. To reinforce the social atmosphere of the meeting, both the teacher and parent might plan to bring food/snacks to share.

Parents as Supporters of School and Children's Learning

1. Develop handouts in parent's native language emphasizing importance of parent involvement.
2. Expand concept of "volunteerism" and actively recruit immigrant parents as classroom volunteers during registration process. For example, volunteer parent may serve as a mentor for newly arriving parents and students. Encourage indirect participation by parents through activities that can be completed at home for use in the classroom. For example, the parent may be asked to create folders for each student for a reading activity. Participation should be on a voluntary basis with all materials supplied by the school.
3. Inform parents well in advance of their child's participation in school activities such as assemblies and programs.
4. Seek out local businesses which are willing to sponsor a "Parent of the Month" through gift certificates or products.

Resources

Coleman, M. & Churchill, S. (1997). Challenges to family involvement. *Childhood Education, 73* (3), 144-154.

Flores, J. L. (1996). *Children of la Frontera: Binational efforts to serve Mexican migrant and immigrant students.* Washington, DC: Office of Educational Research and Improvement.

Macfarlane, E. C. (1996). Reaching reluctant parents. *The Educational Digest, 61* (7), 9-11.

Massachusetts State Department of Education (1990). *Parent-school collaboration: A compendium of strategies for parent involvement.* Quincy, MA: Massachusetts Office of Community Education.

Miller, L. P., & Tanners, L. A. (1995). *Diversity and the new immigrants.* Teachers College Record, 96 (4), 671-676.

Multicultural Education Training and Advocacy (1993). *Attention immigrant parents: Send you child to school.* San Francisco, CA: META.

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Immigrant Teenagers: Helping Them Adjust to Their First Year

Recommendations for Parents

by Bradley Pilon, NCSP, Newcomer Center
Belmont High School (Los Angeles)

- Spend time alone with your child. There is no replacement for time alone, and outings with the entire family don't count. This is especially true if a child is being re-united with his or her parent(s) after a long separation.
- Take time to let your child go over the history of events as they occurred during your absence. Many children don't want to mention the bad things that have happened to protect their parents, yet they also harbor anger that the parents were not there to protect them. They may sound like they understand the need to separate in order for the family to immigrate, but usually still need reassurances to get beyond the feelings of abandonment, no matter how logical and mature they may sound.
- Remember that money does not equal love. The fact that it may have cost a great deal to bring a family to the United States does not mean that the child feels more loved as a result. Adults and children alike need affection to come separately from the mention of money.
- Keep the details of your intimate life private. Children do not need the responsibility of knowing about marital difficulties, past or present, and may feel guilty or overwhelmed if they have taken sides. On the other hand, many children may judge their parents and their relationships, and this is part of the difficulty of raising a teenager, but the teen's opinion should not be used in place of communication between adults.
- Make future goals for yourself and your child. Your child needs to hear how long they are expected to study for their high school diploma without working to help support the family. They also need to hear what your personal goals are for job advancement, living in your current apartment and neighborhood, making trips "back home," and bringing additional siblings or relatives to join the family.
- Demonstrate confidence by delegating responsibility to your son or daughter whenever possible. Give them the benefit of the doubt as often as possible, as opposed to being overly suspicious. Your worry about what kind of trouble your son or daughter might get into could unintentionally lead them toward those things you fear most if voiced often enough.
- Be a good example of what you want from your child. If at all possible, try to attend adult school in the evenings and make an academic goal for yourself, whether it be to finish a specific level of ESL, to complete the eighth grade or high school diploma, or to attend college. This will say more than any lecture you can give your child about the importance of education.
- Provide a calm atmosphere in which to do homework. A clear table and quiet environment during a consistent time period each evening is absolutely necessary. If this is impossible at home, visits to the local library or staying after school to finish homework before leaving may be other options.
- Attend all school functions. Only through meeting teachers and learning about your child's schedule can you effectively talk with your child about his/her progress in school. Teachers will usually remember parents they have met and may be more helpful if they know you are genuinely involved.

- Ask school staff to help with problems. Each school has a Psychologist, Counselors, a School Nurse, and numerous Teachers and Administrators who may have valuable suggestions for how to deal with academic, behavior, health or communication problems, as well as advice regarding low-cost community resources.
- Identify and hold up positive examples of individuals who have "made it" in the way you expect of your child. Avoid pointing to failures unless you can point out a corresponding success. Examples should be brought up at specific times to reinforce good effort, not to induce guilt or shame when the child has committed a mistake.
- Expect the same academic success of both boys and girls. Girls in this country are not necessarily going to get married and stay home after graduation and boys may have to leave their pals when studies require it. "Machismo" conflicts with success in many ways.
- Establish routines in your life. Disruptions such as last-minute trips or overnight visitors can break your child's concentration and studies will suffer.
- Stress the importance of reading. If education is important to you, promote it by making interesting reading material available, such as books, magazines, comic books or newspapers in any language. Library cards are usually free or inexpensive and provide limitless access to such materials. Don't push material which your child finds uninteresting, and don't censor without good cause. For example, comic books can be an excellent, non-threatening way to practice reading and should generally be allowed.
- Limit television. Too much television dulls interest in reading and promotes unrealistic attitudes about success in real life. If your child insists upon some electronic entertainment, music with printed words is better than television.
- Review the basics of good discipline: be consistent in your rewards and punishments, be as specific as possible about what behaviors you expect and select rewards and punishments which are appropriate for the act. Become familiar with what works best as a reward and try to rely more on these positive consequences than on punishment or withholding things.
- Recognize and be proud of the broad world perspective you share with your children. As bilingual, bicultural and travelled members of society you hold certain advantages over people who only know the American culture. There are many opportunities to take advantage of these important assets.
- You will not be able to avoid the hardships of raising a teenager. Expect your child to be at times rebellious and at other times to require nurturing, to sometimes behave maturely and at other times do silly things, or to be moody, or occasionally to be predictable and then surprise you with something unexpected. They will reawaken memories of your own experience as a teenager and you will grow in the process.

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Adolescentes Imigrantes: Ayudédoles a Acomodarse en el Primo Año

por Bradley Pilon, NCSP
Newcomer Center, Belmont High School, Los Angeles

- Pase tiempo a solas con su hijo(a). No se puede sustituir ese tiempo a solas con otras actividades, y excursiones familiares no cuentan. Esto es aún más necesario en el caso del hijo que está reunificándose con sus padres después de una larga separación.
- Tome el tiempo necesario para que su hijo(a) le cuente los acontecimientos tal como ocurrieron durante la separación. Muchos jóvenes son poco dispuestos a contar las cosas malas que les pasaron creyendo que así protegen a sus padres de la verdad, pero al mismo tiempo se quedan con el resentimiento de que sus padres no estaban cuando necesitaban su protección. Aunque muchos dicen que entienden la necesidad de separarse para inmigrar a la familia, siempre necesitan ser reasegurados verbalmente para olvidar sus sentimientos de abandono, incluso los que aparentan ser muy lógicos o maduros.
- Acuérdense que el dinero no equivale al amor. El hecho de que podría haber costado mucho traer a la familia a este país no significa que el/la hijo(a) se siente más querido como resultado. Tanto los adultos como los niños necesitan sentir el cariño aparte de la discusión de dinero.
- Mantenga los detalles íntimos de su vida privados. Los niños no necesitan la responsabilidad de estar enterados sobre las dificultades en el matrimonio, pasadas o presentes, y podrían sentirse o culpables o agobiados si han tomado un lado u otro. Al mismo tiempo, muchos jóvenes juzgan a sus padres y sus relaciones, y ésto es parte de criar a un adolescente, pero su opinión no debe, en ningún momento, reemplazar la comunicación directa entre adultos.
- Trace metas tanto para usted como para su hijo(a). Su hijo(a) necesita oir por cuanto tiempo usted quiere que estudie para su diploma sin trabajar para ayudar a la familia. También se beneficiaría de oirle mencionar sus metas personales en cuanto al trabajo, la estancia esperada en su apartamento y vecindad, los viajes de regreso al país natal y fechas posibles de mandar a traer a otros familiares para unir más a la familia.
- Demuestrele la confianza dándole responsabilidades a su hijo(a) lo más posible. Busque lo positivo en vez de esperar lo peor. Sus preocupaciones sobre el tipo de problemas que les podrían llegar podrían guiarlos hacia precisamente lo que usted quiere evitar si son mencionados mucho o en mucho detalle.
- Sea un buen ejemplo de lo que quiere ver en su hijo. Si es posible, trate de asistir a la escuela de adultos en las noches y escoja una meta, ya sea solamente de terminar un cierto nivel de Inglés, terminar su diploma del grado ocho o de high school, o asistir a la universidad. Esto le comunicará más que cualquier consejo que usted le puede dar sobre la importancia de la educación.
- Provea un ambiente tranquilo para hacer tareas: una mesa limpia y silencio sin distracciones durante el mismo período cada noche. Si no se puede en casa, visitas a la biblioteca por la noche u horas de escuela extendidas para terminar con la tarea antes de salir, podrían ser alternativas.
- Asista a todas las funciones escolares. Solo conociendo los maestros, las clases y la rutina de la escuela podrá conversar con su hijo acerca de su progreso en la escuela. Los maestros recordarán a los padres que han conocido y estarán más dispuestos a acomodar cualquier petición especial que tengan.

- Pida ayuda al personal de la escuela con sus problemas. Cada escuela tiene un psicólogo, muchos consejeros, una enfermera y muchos maestros y administradores que pueden brindarles muchos consejos ya sean para solucionar problemas académicos, de comportamiento, de salud o en comunicación. También están al tanto de muchos recursos grátis en la comunidad.
- Identifíque y señale ejemplos positivos de indivíduos que han sobresalido de tal modo que usted espera ver a su hijo(a). Evite indicar los fracasos a menos que puedan nombrar un éxito correspondiente. Estos ejemplos deben ser mencionados en ocasiones específicas para reenforzar el buen esfuerzo, no solo para inculcar vergüenza o culpabilidad cuando el jóven haya cometido un error.
- Exija éxito en la escuela tanto de una hija como de un hijo. Las muchachas que viven en este país no serán necesariamente amas de casa por toda la vida y los muchachos en ocasiones tendrán que escoger entre el estudio y el andar con amigos. "El machismo" interfiere con el éxito en muchas maneras.
- Establezca rutinas en su vida cotidiana. Las interrupciones como viajes improvistos o huéspedes por una noche interrumpen la concentración de su hijo(a) y los estudios pueden sufrir.
- Enfatice la importancia de la lectura. Si le importa mucho la educación, promuévala con proveer materiales interesantes para leer, tal como los libros, las revistas, las revistas de historietas ilustradas y los periódicos — en cualquier idioma. El precio actual de las tarjetas de biblioteca en Los Angeles es de cincuenta centavos y ofrece acceso sin límites a muchos materiales. No le presione a su hijo(a) con materiales que no le parecen interesantes, y no le censure sin buen motivo. Por ejemplo, las historietas pueden representar una excelente fuente de práctica para la lectura y se le deben permitir.
- Ponga restricciones al uso de la televisión porque en exceso les impide la curiosidad natural e inculca ideas no realistas sobre el trabajo y la superación en el mundo real. Si su hijo(a) insiste en acudir al entretenimiento electrónico, más vale la música con su letra impresa que la televisión.
- Repase los principios de la disciplina eficaz: Sea consistente en sus premios y castigos, sea lo más específico posible sobre la conducta que usted espera ver y escójales premios y castigos que sean los más apropiados al comportamiento. Aprenda las consecuencias positivas que motivan más y trate de usar éstas, en vez de las negativas o el negársele lo que le gusta.
- Esté consciente y orgulloso de la amplia perspectiva mundial que usted comparte con su hijo(a). Como personas bilingues-biculturales y que han viajado, ustedes disfrutan de ciertas ventajas comparado con personas que solo conocen la cultura Americana. Hay muchas oportunidades para aprovecharse de estas ventajas.
- No hay manera de evitar las dificultades de criar a un adolescente. A veces se portarán rebeldes mientras en otras ocasiones querrán que se les consienta; a veces demuestran madurez y de repente cometen tonterías; pueden estar sentimentales; o vacilan entre predicibles y caprichosos. Despiertan memorias en uno de su propia adolescencia y le inducirán a crecer como persona en el proceso.

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Limited English Proficiency

A Handout for Teachers

by Diane K. Wilen, Ph.D., NCSP
Broward County (FL) Public Schools

Background

Cultural diversity is widespread within the United States and is mirrored within American schools. With this diversity come growing numbers of children whose native language is not English and who may be described as Limited English Proficient (LEP) or English Language Learners (ELL). There are very large populations of ELL students in California, New York, Texas, Illinois, New Mexico, Arizona, New Jersey and Florida. However, ELL students are present to some degree in virtually every state. Many of these ELL students are immigrants and refugees, but others were born in the United States. School dropout rates are often high among ELL populations.

The availability of bilingual education, ESOL, ESL and other special programs for ELL students differs across states and school districts. Even if students receive specialized services for their limited English proficiency, their teachers may neither speak their home language nor have direct experience with their culture.

Development

Previous life experiences, family issues, behavioral adjustment, academic performance and the second language acquisition process are all important for teachers to consider in evaluating the current status of ELL students.

Life Experiences: ELL children have often been exposed to stressful or traumatic life experiences at a very young age. They may have endured war, political strife, separation from parents and siblings, frequent moves, poverty, hunger, overpopulated refugee camps, dangerous exoduses from their countries and general uprooting. Others who are in the United States illegally live in fear of the authorities.

Medically, many ELL children are in need of services which may not have been affordable or available to them in their countries. Vision, hearing, general physical and dental exams are often indicated.

Educationally, some ELL students have a history of inconsistent schooling. Many come from countries where education is not mandatory or even available to all children. Children may have attended overcrowded schools with limited resources. Some may have been forced to drop out of school to go to work while others, especially those with mental or physical handicaps, may have been denied education in their native countries. Lack of availability of special education programs for handicapped children may actually have been the impetus for coming to the United States.

Culturally, ELL children come to school with a set of experiences, customs and values which differ from those of other students. They may celebrate different holidays and may not be familiar with American celebrations such as Halloween and Thanksgiving. Often, they eat different foods and have different meal times. Their clothing may be different. They may have different standards of etiquette. They may write their names in a different order (e.g., last, middle, first for Vietnamese) or may not write the date according to the United States custom of month, day, year (e.g., day, month, year for Hispanics). They may have different concepts of time and punctuality.

Family Issues: Because families of ELL children often lack English literacy, they can have difficulty participating in the educational process of their children. They may have trouble helping with homework and may feel inadequate to attend conferences or ask questions of educators. Often, they have different childbearing practices and values. What may be perceived by American teachers as overindulgence and lack of responsibility may be appropriate in a ELL family's culture.

Behavioral Adjustment: ELL children may manifest behaviors ranging from passivity to acting out upon entering the American school. They often experience temporary adjustment problems because of all of the stresses and changes they face in adapting to a new country, language, culture, school and life situation. They need time to adjust to their new environment.

Academic Performance: ELL children come to school with varying degrees of literacy in their own language and in English. Their language may not have the same alphabet as English and may be written in a different fashion (e.g., Hebrew has different characters and is written from right to left). This may make learning English even harder. They may have experienced different teaching styles (e.g., more emphasis on rote as opposed to analytical methods). English oral communication skills are generally mastered more quickly than reading and written language skills. Learning to read in English is often easier to those already literate in their native language. Current academic performance should be interpreted in light of educational background and life experiences. ELL students may have started school at a different age than is customary in the United States and may have come from schools where grade levels do not correspond with the K-12 system.

Second Language Acquisition Process: Second language acquisition emerges through developmental stages and is time intensive. ELL students generally acquire English conversational skills well before they attain the level of language proficiency required for success in academic classes taught entirely in English. Proficiency in the first language, motivation, self-esteem, practice, comprehensible input and appropriate instruction facilitate second language acquisition.

What Can I Do As a Teacher?

- Learn as much as possible about the cultural and language background of ELL students by reading, attending courses and speaking with minority language groups.
- Ask ELL students by what name they would like to be addressed and how to pronounce it correctly.
- Provide comprehensible instruction at a level commensurate with a student's language proficiency skills.
- Pair a new ELL student with a veteran ELL student who can be a "buddy" and who preferably speaks the same language as the ELL student.
- Encourage homework hotlines staffed by bilingual teachers or aides to assist ELL students.
- Teach survival English first (e.g., bathroom, cafeteria, book, pencil) and label common objects in the classroom in English.
- Use a dictionary which contains translations from English to the child's native language and vice versa.
- Pair visual cues and nonverbal gestures with verbal communication in the classroom. Speak English slowly and give short, concise directions. Observe ELL children to see if they understand what they are to do. Repetition may be needed.
- Encourage natural and purposeful communication in the classroom.
- Use mechanical aids such as language masters, tape recorders, overhead projectors and computers as well as realia, music, art, games and hands-on experiences to reinforce learning.

- Use cooperative learning groups to promote peer interaction and active learning.
- Enhance self-image, motivation and cultural pride by using culturally relevant materials and encouraging presentations about native foods, customs, costumes, dances, holidays and famous minority language individuals.
- Encouraging participation in extracurricular activities.
- Encouraging development of talents and special abilities.
- Encourage parent participation by calling the family if they do not respond to notes sent home, by using social workers to make home visits, and by communicating with parents in their native language whenever possible. The use of interpreters or bilingual school staff can often facilitate the latter.
- If students exhibit academic or behavior problems which appear unusual or extreme in comparison to other *ELL students*, seek help from other professionals such as school psychologists, social workers and counselors.

Resources

Fradd, S.H., McGee, P.L. with Wilen, D.K. (1994). *Instructional assessment: An integrative approach to evaluating student performance.* Reading, MA: Addison-Wesley. This book provides practical information on appropriate assessment and educational planning for non-English language background students. It includes valuable case studies of typical students in the process of learning English as well as special needs students.

Scarcella, R. (1990). *Teaching language minority students in the multicultural classroom.* Englewood Cliffs, NJ: Prentice Hall Regents. This book offers content-area teachers and other educators suggestions and instructional strategies to foster the school progress of language minority students. It includes providing comprehensible lessons, appealing to multiple learning styles, encouraging parent involvement and incorporating students' languages and cultures into the curriculum.

The National Clearinghouse for Bilingual Education provides valuable materials, discussion groups, and an on-line library. Web site: *<http://www.ncbe.gwu.edu>*
e-mail: *<askncbe@ncbe.gwu.edu>*
Phone: (800) 321-NCBE and (202) 467-0867
U.S. mail address: 1118 22nd Street, NW, Washington, DC 20037

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Migrant Students: Ten Facts About U.S. Schools

A Handout for Parents

by Robert Rhodes, Ph.D. and Doris Paez, Ph.D.
New Mexico State University

Background

All parents make important decisions about their children's education. To make good decisions, parents need good information. Many parents who work in seasonal or migrant jobs must often make decisions about their children's education without first-hand knowledge of the United States public school system. The following is a list of ten important things for parents to know about U.S. schools:

1. **School is free.** All children living in the United States have the right to a free public education.
2. **All children may register for school.** Children do not need a green card, visa, passport or other proof of citizenship or immigration status to register for school. Parents may be asked to provide proof of residency within the school district, a birth certificate and immunization records.
3. **All children living in the United States are required to attend school.** The ages for mandatory school attendance vary from state to state. Some states require children to begin school as early as age five or six and continue until age seventeen or eighteen. Check with your local school for the required ages in your state and the number of excused absences allowed each year.
4. **All children who need special help are welcome at school.** Children who need special help to learn also have the right to a free public education. This includes children who have learning disabilities, autism, physical or medical concerns, speech and language difficulties, behavioral or emotional concerns, or any other special education need.
5. **Parent permission is important.** Parents must give their permission in writing before children can receive any type of special services at school.
6. **Special education services are available at any school in the United States.** Whether you move to a big city or small town, your child has the right to continue receiving special help.
7. **All children are allowed to progress from grade to grade.** Unlike some school systems, there is a limit to the number of times a student may be required to repeat a grade within the United States (usually once, and most school districts discourage more than one retention throughout the school career). Students who need extra help are typically able to receive this help while progressing from grade to grade with their peers.
8. **Student records can be sent from school to school** anywhere in the United States. To ensure that students receive the help they need, records are kept at each school and are sent to the next school when a student moves. It is important that you know the name and address of each school your child has attended and that you give permission for any special education records to be sent to the new school. As a parent you also have the right to have a copy of your child's student record and to review any information that it contains.

9. **Transportation is provided for children.** Children who live too far from school to walk and children who need special help to get to school are able to ride a school bus back and forth each day.

10. **Meals are provided for children.** For children whose families have limited incomes, breakfast and lunch are provided for free or at a reduced cost. Check with your local school to find out more information and to apply for this program.

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Estudiantes Migratorios: 10 Datos Sobre las Escuelas Americanas

Información para Padres

by Robert Rhodes Ph.D., y Doris Páez, Ph.D.
Universidad Estatal de Nuevo México

Antecedentes

Todos los padres hacen decisiones importantes sobre la educación de sus hijos. Muchos padres quienes son empleados como trabajadores migratorios o estacionales, frecuentementemente tienen que hacer decisiones sobre la educación de sus niños sin tener conocimiento del sistema de escuelas públicas de los Estados Unidos. Para poder hacer buenas decisiones hay que tener información buena. La siguiente es una lista de diez cosas importantes que los padres deben saber sobre las escuelas públicas de los Estados Unidos:

1. **La escuela pública es gratis.** Todos los niños que viven en los Estados Unidos tienen el derecho a una educación pública.

2. **Todos los niños pueden matricularse en la escuela.** Los niños no necesitan una tarjeta verde, visa, pasaporte, u otra demostración de condición de inmigración o ciudadanía para matricularse en la escuela. Las escuelas pueden exigir prueba de residencia dentro del distrito escolar, un certificado de nacimiento, y registros de inmunizaciónes.

3. **A todos los niños que viven en los Estados Unidos se les requiere que vayan a la escuela.** Las edades para la asistencia mandataria en la escuela varía de estado a estado. Algunos estados requieren que los niños empiecen a los cinco o seis años de edad y que continúen hasta la edad de diecisiete o dieciocho. Los padres deben verficar con la escuela cuales son las edades requeridas en el estado. Además, los padres deben averiguar cuantas ausencias se permiten cada año.

4. **Las escuelas tienen que aceptar a todos los niños.** Todos los niños tienen derecho a una educación pública. Esto incluye a los niño que tienen o ya han sido identificados con desabilidates emocionales, físicas, mentales, trastornos de salud, o cualquier condición que les impida aprender bien.

5. **El permiso de los padre es importante.** Los padres tienen que dar permiso por escrito antes de que su hijo/a pueda recibir cualquier tipo de ayuda especial en la escuela.

6. **El servicio de educación especial se encuentra en cualquier escuela pública en los Estados Unidos.** No importa que sea ciudad urbana, rural, grande o pequeña. Si su hijo/a tiene derecho a recibir cualquier ayuda especial para que pueda aprender, la escuela se lo tiene que dar.

7. **A todos los niños se les permite progresar de grado a grado.** Aunque hay variedad entre distritos escolares en los Estados Unidos, todos tienen límites sobre el número de veces que un estudiante puede repetir un grado. Los estudiantes que necesitan ayuda especial, típicamente pueden recibirla mientras progresan de grado a grado para poder graduarse con compañeros de su misma edad.

8. **Los datos de un estudiante se pueden enviar de escuela a escuela para asegurar que el niño reciba todos los servicios necesarios.** Los expedientes se guardan en cada escuela y se envian a la próxima escuela cuando el estudiante se traslada. Es importante que usted sepa el nombre y la dirección de cada escuela que su hijo/a ha asistido. Los padres también tienen el derecho de obtener una copia del expediente de sus hijos y revisar cualquier información que contienga.

9. **La escuela transporta a los niños.** Los niños que viven muy lejos de la escuela para caminar y los niños que necesitan ayuda especial para asistir a la escuela son transportados por el autobus/ camión de la escuela.

10. **La escuela alimenta a los niños.** Hay un programa federal que alimenta a los niños pobres. El desayuno y el almuerzo es gratis or ha costo reducido para familias que caen entre los reglamentos. La escuela tiene que darle esta información y ayudarle a hacer aplicación a este programa.

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Second Language Acquisition

A Handout for Educators

by Diane K. Wilen, Ph.D., NCSP and Barbara Diaz, Ed.S., NCSP
Broward County (FL) Public Schools

Background

English Language Learners (ELLs), also referred to as Limited English Proficient (LEP) students, come from a myriad of countries worldwide including the United States, and have varying levels of proficiency in their native language as well as in English. In order to effectively educate and serve the increasing population of ELLs in U.S. schools, teachers and support personnel, such as school psychologists, guidance counselors, social workers, speech/language pathologists and exceptional student education specialists, need to understand second language acquisition.

For ELLs, second language acquisition is a lengthy, developmental process whereby students whose native language is not English acquire listening, speaking, reading and writing skills in English. Simultaneously, ELLs face the task of mastering content area instruction in subjects such as mathematics, social studies and science which are generally taught in English. Second language acquisition involves not only language and academic components, but cognitive and sociocultural components as well (Collier, 1995).

School personnel need to understand second language acquisition in order to promote success in their English language learners. Key aspects of language proficiency, confusion between second language learning and handicapping conditions, language loss or regression, and assumptions and misconceptions about second language learning are discussed next.

Development

Language Proficiency: There is a vast difference between the development of the native, or first language, and the subsequent learning of a second language. Central to the understanding of the process of second language acquisition is Cummins' theory of language proficiency. In order for a student to become proficient in a second language, both basic interpersonal communication skills (BICS) and cognitive academic language proficiency (CALP) need to be developed. The latter is the basis for a student's academic success but may take anywhere from 5 to 7 years, or longer, to master. Basic interpersonal communication skills, in contrast, are usually attained within the first two years of exposure to a second language and are characterized by superficial oral language skills. Language proficiency develops along continuums: from context-embedded to context-reduced communication, and from cognitively undemanding to cognitively demanding tasks.

In *context-embedded communication*, information is obtained from cues in the environment. In comparison, *context-reduced communication* involves abstractions that are more difficult to comprehend without specific knowledge of the particular system. *Cognitively undemanding* tasks are routine and easy to accomplish while *cognitively demanding* tasks are harder and depend on concept manipulation.

Cognitive Academic Language Proficiency: It is easy to assume that, once ELLs can speak English, they can complete academic tasks in English. However, this may not be the case. Cognitive academic language proficiency is a complex process that is impacted by previous schooling, age and cultural experiences. Students who have had 2 to 3 years of schooling in their native language may require 5 to 7 years to obtain academic proficiency in the second language, while students who have never received native language schooling may take 7 to 10 years to obtain proficiency. Considering children across age levels beginning to learn English, the 8 to 11 year-old age group who have literacy skills in their first language are generally the first to obtain academic proficiency. The preschool population will generally take longer because their first language was not fully developed before the second language was introduced.

Second Language Acquisition versus Handicapping Conditions: Many of the behaviors of students acquiring a second language are easy to confuse with those of students with handicapping conditions. Experiential differences can often cause confusion between these two groups of students. Some ELLs come from war-torn or agrarian countries. Others have lived in extreme poverty with little or no formal schooling. When compared with the second language culture, these students may appear to be functioning below their abilities.

There are linguistic similarities between these two groups of students such as syntax, language use, phonology, vocabulary and articulation errors. Language interference should be distinguished from disabilities. Normal second language learners often make errors wherein a communication behavior from the first language is incorrectly transferred to the second language. In addition, ELLs often go through a silent stage which may be misinterpreted as a sign of emotional or academic difficulties.

Then, there is also the process of acculturation. During this process, students may demonstrate a short attention span, distractibility, anxiety, resistance to change and confusion in their locus of control. Added to this are cultural differences in nonverbal and sociolinguistic communication, interaction patterns and survival skills. For example, some cultures foster complete compliance and submissiveness and different body language such as touching, movement and proximity to others.

Language Loss/Language Regression: A regression in the native language may occur due to a lack of continued exposure to the more complex concepts in that language and to the introduction of a second language before the first language is fully developed. During this time, there may appear to be a lack of proficiency not only in the second language, but also in the first. If a child is not competent in his/her native language, it will affect his/her competence in the second language. Native language loss may also occur although the language is still being used in the home. Therefore, a child may no longer be proficient in the first language, but may lack proficiency in the second language as well, due to limited exposure.

Assumptions and Misconceptions: There are a number of additional assumptions and misconceptions regarding the process of second language acquisition. One misconception is that children learn a second language more rapidly and easily than adults. This occurs because children's language competence expectations are lower than those of adults. Another misconception is that the more time that ELLs spend immersed in the second language, the faster that language may be learned. However, children who establish competency in their first language will have an easier time developing the second language.

Inappropriate assumptions are often made on the basis of sex, race, culture, and socioeconomic differences. Another incorrect assumption may be equating the educational experiences of ELLs with those of native born students. In addition, false assumptions are often made regarding the families of ELLs. These assumptions may relate to parental expectations and attitudes toward school, motivation and discipline. All of these elements impact the second language acquisition process.

What Can Teachers and Support Personnel Do?

- ***Adapt curriculum, instruction and materials*** in all subject areas so they are understandable for ELLs. This could include adjusting language complexity of teacher talk and assignments to student language proficiency levels; using gestures, drawings, charts, demonstrations, experiments, real objects, pictures and hands-on tasks to reinforce concepts; using outlines, definition lists and emphasis on key points to enhance comprehension; providing clear, concise examples and simplifying instructions.

- ***Establish a classroom routine*** so that ELLs know what to expect.
- ***Provide prerequisite or background information*** before giving an assignment. This may be missing from a student's experiences.
- ***Establish high expectations for learning.*** Reduce the language demands of tasks, not the level of conceptual skills, reasoning or problem-solving skills required. Expand vocabulary as students' language increases.
- ***Be enthusiastic and motivating.*** Make assignments relevant and interesting to ELLs.
- ***Encourage communication*** both inside and outside of class. Provide opportunities for interpersonal interactions and topical conversations in the classroom.
- ***Model correct communication*** rather than directly correcting student errors in grammar and syntax, for example.
- ***Use multiple methods*** such as journals, portfolios, dialogues, plays, story writing, oral and written language samples, and group projects to encourage language development.
- ***Utilize dual language dictionaries*** in the native language and in English in the classroom.
- ***Develop district-wide academic games, fairs, and competitions*** for ELLs and facilitate their active participation.
- ***Encourage home language:*** When working with parents, do not tell them to de-emphasize the use of the native language in the home. Use of the home language will facilitate concept development, and will help the student become bilingual.
- ***Background information*** is critical in distinguishing the normal second language acquisition process from handicapping conditions. It is important to know whether students had any academic or language problems in their native language before exposure to a second language began. It is also important to assess students in the native language and in English before diagnosing ELLs as handicapped.
- ***Try to learn some social greetings and common expressions*** in the native language of the ELLs you serve. Use these greetings and expressions to make students and parents feel comfortable in school and to facilitate second language learning.
- ***Collaborate:*** In planning instruction and assessment for ELLs, collaborate with teachers and support personnel who have experience and expertise in the education of ELLs and in second language acquisition.
- ***Allow students to demonstrate skills and knowledge*** in the native language while they are learning English.
- ***In testing students,*** use tests with demonstration, practice, and sample items; which have reduced language demands; which allow extended time limits; which allow the use of bilingual dictionaries; and which allow for response modes consistent with the ELLs' level of language proficiency, if possible and appropriate to the testing situation. Relative to response modes, for example, the ELL at the early stages of second language acquisition will likely do better with matching items than with items requiring more verbal production.

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Tolerance and Diversity

Resources for Parents, Educators and Students

by Deborah Crockett, Ph.D., NCSP
Atlanta Public Schools

These resources are intended to supplement instruction in school and other settings. The ultimate goal is to increase the understanding, acceptance and awareness of diversity in our daily lives. This bibliography serves as a sample of resources available for professionals, parents and students.

Readings

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NATIONAL
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PSYCHOLOGISTS

by Henry J. Srednicki, Ph.D., NCSP
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Bus Safety

A Handout for Parents and Teachers

Background

Approximately 400,000 yellow school buses serve elementary and high school students in the United States. In all, about 22.5 million school-age children ride yellow school buses to and from school. After-school activities provide an estimated 5 million additional student rides on a daily basis. It is also estimated by the American Public Transit Association that public transportation provides an additional 900 million student rides per year. You may also be surprised to learn that this makes school transportation the single largest system of public transportation in the United States, resulting in over 94.2 billion total pupil-passenger miles per year.

Most of us recall one incident or another whereby a student was harmed from some avoidable mishap that occurred while riding or walking to the school bus. According to the National Highway Traffic Safety Administration, an average of 41 school-age children are killed in school bus-related traffic accidents each year. During the past ten years, 300 school-age pedestrians (less than 19 years old) have died in school-bus related crashes. Numerous injuries also have occurred when riding, boarding or unloading from a school bus.

Issues Involving School Bus Safety

While school bus transportation is regarded by many as one of the safest forms of transportation, accidents do happen. Typically, children are no longer under the supervision of teachers or parental figures when riding the school bus. Such unstructured situations often lead to misconduct and episodes of poor judgment on the part of some students. Situations that may arise resulting from disruptive behavior may be distracting to the driver or may encourage a student to take unnecessary risks, such as waving an arm out a school bus window, often to the dismay of a parent.

School bus drivers often report that they are overwhelmed by what they see as students' lack of respect and failure to follow school bus rules and regulations. Typically, a large school bus will transport 54 students, a number of students far in excess of what a certified teacher would be permitted to supervise without assistance. Yet, this is asked of school bus drivers across the country on a daily basis.

Of students who have died in school bus-related incidents, almost two thirds were killed by school buses, 6% by vehicles functioning as school buses and 30% by other vehicles involved in crashes with school buses. Five- and six-year-olds represented more than half of all school-aged pedestrians killed by school buses over the past ten years. On average, 21 school-age pedestrians are killed by school buses each year and 9 are killed by other vehicles involved in school bus crashes. Of those children killed, 42% are killed in crashes between 3:00 and 4:00 p.m. — enroute home from school."Inattention" and "failure to yield" were factors most often reported by police for school bus drivers striking school-age pedestrians.

While efforts have been made to require seat belts on large school buses, only two states currently mandate seat belts in school buses (New Jersey and New York), while the federal Government mandates seat belts in all small buses (under 10,000 lb.). Ironically, studies dating back to 1969 have repeatedly concluded that compartmentalization provides better protection in accidents than two-point seat belts on school buses. To date, there have been no studies conducted on three-point seat belts and safety.

School Bus Safety: Prevention

The best solution to the issue of school-bus safety is one of prevention. Children and their parents, as well as educators and community members, need to be aware of the risks involved with children and school buses. Motorists also need to obey all state regulations regarding driving in the vicinity of school buses and their designated drop-off zones.

A good way to raise the level of awareness in the community is through the implementation of a school bus safety program. "Operation School Bus Safety" is one such program available from the Nation PTA[1] and Navistar International, designed to help communities improve bus safety records and protect children. Moreover, school bus safety week is usually held in late October, which is a good time to highlight such programs. In general, children should understand that riding on the bus is a privilege, that the bus is an extension of school and they are expected to behave as well as they would in their classroom. Parents and educators wishing to initiate a prevention program are encouraged to contact their local PTA for information on "Operation School Bus Safety." Educators and parents can also help by reminding students to follow some very simple safety rules which are outlined below:

School Bus Safety Rules

On the way to the bus:

- Be alert, arrive at your stop at least five minutes early.
- Always obey all traffic lights and signals.
- Plan to walk with schoolmates whenever possible, facing the traffic.
- When crossing streets, always cross at crosswalks and intersections.
- Look both ways before crossing the street.

At the bus stop:

- Stand back from the curve.
- Don't push or shove when entering or exiting and always use the steps and hand rail.
- Always obey the bus driver and wait for the driver's signal before crossing.
- Always cross at least 10 feet in front of the school bus.
- Never, never crawl under the bus.

When riding the bus:

- Take your seat quietly and quickly, remain seated when the bus is moving and don't get out of your seat when the bus is moving.
- Keep your feet on the floor and never ever extend your hands, arms, head or any object out the window of a bus.
- Talk in a conversational tone, be courteous to the driver and schoolmates, and try not to distract the driver through misbehavior.

[1] Contact the National PTA at 330 N. Wabash Av., #2100, Chicago IL 60611; (312) 670-6782.

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Critical Incident: Stress Information

by Servio Carroll, Ed.S., NCSP
Crisis Intervention Team, Sheridan WY

Emotional After-Shocks

You have experienced a traumatic event or a critical incident. A critical incident is any incident that causes one to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later. Even though the event may be over, you may now be experiencing or may experience later, some strong emotional or physical reactions. It is very common, in fact quite *normal*, for people to experience emotional after shocks when they have passed through a horrible event.

Sometimes the emotional after shocks (stress reactions) appear immediately after the traumatic event. Sometimes they may appear a few hours or a few days later. In some cases, weeks or months may pass before they appear.

Symptoms of Stress Reaction

The signs and symptoms of a stress reaction may last a few days, a few weeks, or a few months and occasionally longer depending on the severity of the traumatic event. With understanding and the support of loved ones the stress reactions usually pass more quickly. Occasionally the traumatic event is so painful that professional assistance from a counselor may be necessary. This does not imply craziness or weakness. It simply indicates that the particular event was just too powerful for the person to manage by themselves. Symptoms:

Physical	Cognitive	Emotional	Behavioral
• fatigue • nausea • muscle cramps • twitches • chest pain • difficult breathing* • elevated BP • rapid heart beat • thirst • headaches • visual difficulties • vomiting • grinding of teeth • weakness • dizziness • profuse sweating • chills • shock symptoms* • fainting • etc. * *Needs Medical Attention*	• blaming someone • confusion • poor attention • poor decisions • heightened or lowered alertness • poor concentration • memory problems • hypervigilance • difficulty identifying familiar objects or people • increased or decreased awareness of surroundings • poor problem solving • poor abstract thinking • loss oftime, place or person orientation • disturbed thinking • nightmares • intrusive images • etc.	• anxiety • guilt • grief • denial • severe panic • emotional shock • fear • uncertainty • loss of emotional control • depression • inappropriate emotional response • apprehension • feeling overwhelmed • intense anger • irritability • agitation • etc.	• change in activity • change in speech patterns • withdrawal • emotional outbursts • suspiciousness • change in usual communications • loss or increase of appetite • alcohol consumption • inability to rest • antisocial acts • nonspecific bodily complaints • hyperalert to environment • startle reflex intensified • pacing • erratic movement • change in sexual functioning • etc.

Consider These Suggestions for the First 24 to 48 Hours:

- Alter periods of exercise with periods of relaxation.
- Structure your time, keep busy.
- Reassure yourself that you are normal and having normal reactions. Don't label yourself crazy.
- Talk with others. Talking about it is healing.
- Avoid caffeine: coffee, chocolate, tea, sodas, etc.
- Reach out. People do care. Spend time with others.
- Maintain as normal a schedule as possible.
- Avoid the use of drugs and alcohol. Don't complicate the problem with substance abuse.
- Give yourself permission to feel rotten. It's normal.
- Keep a journal, write through those sleepless hours.
- Do things that feel good to you.
- Realize that those around you are also under stress.
- Don't make any big life changes.
- Do make routine daily decisions. Regain control.
- Eat regular meals, even if you don't feel like it.
- Get plenty of rest, as much as you can.
- Flashbacks are normal, don't fight them. They'll decrease in time and become less painful.

Resources

Seek professional help from a mental health provider or your physician if you feel overwhelmed. It's Okay. They are trained to help you deal with these strong emotional reactions. It's not a sign of weakness.

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Death: Dealing with Crisis at School

Practical Suggestions for Educators

by the Department of Psychological Services
Cypress-Fairbanks ISD, Houston, TX

Background

National statistics indicate that approximately one out of every 1500-2000 students die or is killed each year, with the incidence of deaths being highest for the high school population. The most frequent causes of student deaths are accidents, homicide and suicides. The Center for Disease Control (CDC) statistics from 1994 indicated the following causes of deaths among young people under age twenty:

1. 4000 motor vehicle deaths
2. 4000 homicides
3. 3800 suicides

The CDC statistics also indicate that approximately 50 homicides or suicides happened on school grounds or on the way to school in 1995.

Unfortunately, at some time all educators will deal with the death of a student or colleague. It is then essential that school personnel prepare *in advance* so that they can respond in a timely and supportive manner that leads to constructive resolution for all students and staff.

Notification and Announcement Procedures

- **Get the facts!** Verification is very important and administrators should contact the family of the deceased and/or authorities to get the facts before providing post-vention. Give everyone the facts as quickly as possible to dispel rumors. Age-appropriate language should be used.

- **Establish a calling tree:** A calling tree should be utilized to notify district level personnel as well as building staff in the location where the deceased attended or worked. The calling tree can be used to notify all school personnel that a faculty meeting will be held before school to outline post-vention plans. If the death occurs during non-school hours or during vacations, this process allows staff members to work through their own issues before they assist their students.

If a Death Occurs When School is in Session

1) **Hand deliver a memorandum to all teachers:** The most frequent recommendation is to give all teachers the facts about the tragedy and instructions to share the information with their students, as well as suggestions for assisting students. This memo can also invite all staff to a faculty meeting after school. The majority of students should stay in their classroom. Only those closest to the victim or those with tragic life situations of their own should be sent to the school's support personnel.

2) **Use the public announcement system:** The administrator is urged to carefully plan and rehearse what he will say. Choice of words, voice tone and inflection are very important and set the tone for management of the tragedy.

Determine the Degree of Trauma

The following questions will help the administrator anticipate the amount of emotional trauma:

- Who was the person and were they a long-time popular member of the school?
- What happened? Murder and suicide are unexpected and violent, and thus more difficult to deal with than, for example, a death from a serious illness.
- Where did the death occur? A death that occurs on school grounds is more difficult to deal with. It is important to find out who witnessed the death and provide them with counseling. Students may also reflect concerns with personal safety.
- What other tragedies have impacted this particular school recently? The latest death will cause other unresolved issues to surface for both staff and students.
- Who was the perpetrator? If the person believed to be responsible for the death is also a member of your school community, it adds to the emotionality.

Roles for School Personnel

There are a number of roles that should be performed by key personnel. It is important to recognize that each person has his or her own unique history with regard to crisis and loss. It is not unusual for old issues to resurface. Each student should be given permission to feel a range of emotions. There is no right or wrong way to feel. Typically, individuals go through a sequence of emotional reactions following a crisis: 1) high anxiety, 2) denial, 3) anger, 4) remorse, 5) grief, and 6) reconciliation.

Principal's Role

- Direct intervention efforts
- Be visible, available, supportive and empower staff
- Provide direction to teachers about how much to set aside the curriculum. Tests should be postponed in some classes.
- Communicate with central administration and other affected schools
- Contact family of the deceased
- Inform staff and students about funeral arrangements
- Ensure that memorials are appropriate

Counselor's/School Psychologist's /Social Worker's Role

- Be available
- Cancel other activities
- Locate counseling assistance (check community resources)
- Provide individual and group counseling
- Contact parents of affected students with suggestions for support or further referral
- Follow the schedule of the deceased and visit classrooms of close friends
- Support the faculty (provide counseling as needed)
- Keep records of affected students and provide follow-up services

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Teachers' Role

- Provide accurate information to students
- Lead classroom discussions that focus on helping students to cope with the loss
- Dispel rumors
- Answer questions without providing unnecessary details
- Recognize the varying religious beliefs help by students
- Model an appropriate response
- Give permission for a range of emotions
- Identify students who need counseling and refer to building support personnel
- Provide activities to reduce trauma, such as artwork, music and writing
- Set aside the curriculum as needed
- Discuss funeral procedures

What If the Death Was a Suicide?

If the death was a suicide, post-vention procedures outlined by the American Association of Suicidology (AAS) should be followed, in addition to the recommendations above. The tasks of post-vention are twofold: 1) to reduce the chances of anyone else committing suicide by avoiding glamorization of the deceased and 2) to assist staff and students with the grieving process. Post-vention activities provide an opportunity to teach students the warning signs of suicide so that further suicides can be prevented. It is also important that school personnel receive training to recognize symptoms of depression and warnings of suicide ideation among students well before a crisis occurs. The main recommendations of the AAS include the following:

- Don't dismiss school or encourage funeral attendance during school hours
- Don't dedicate a memorial to the deceased
- Don't have a large school assembly
- Do give the facts to the students
- Do emphasize prevention and everyone's role
- Do provide individual and group counseling
- Do emphasize that no one is to blame for the suicide
- Do emphasize that help is available and that there are alternatives to suicide
- Do contact the family of the deceased

Resources

American Association of Suicidology, Suite 310, 4201 Connecticut Av NW, Washington, DC 20008.

Pitcher, G., & Poland, S. (1992). *Crisis intervention in the schools.* New York: Guilford Press.

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National
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Disasters: Developing A Crisis Response Plan

Guidelines for School Personnel

by Debby Waddell, Ph.D., NCSP, Columbus, OH
and Alex Thomas, Ph.D., NCSP, Miami University (OH)

Background

Disasters can take many forms. They may be weather-related, as in tornadoes, hurricanes, or floods;accident-related, as in bus or automobile deaths or drowning; illness-related as in AIDS, cancer or other deaths due to illness, or bizarre and unusual, as in the case of snipers or a murder. For some of these disasters, pre-planning can be done, i.e., when death from cancer is anticipated or when weather forecasts warn of hurricanes. Others may be sudden and allow no time for pre-planning. Yet another variable is whether the disaster occurs at school (i.e., a suicide in the school or a tornado during school hours) or outside of school hours (i.e., weekend hurricane or automobile accident). All of these factors will undoubtedly affect the specific response to the disasters, but some common elements can be found in all of these situations.

Formulating a Disaster Plan

When disaster strikes, teachers and school staff members immediately need to be ready to cope with their reactions and the reactions of their students. The need to deal with student reactions comes at a time when staff members are still dealing with their own reaction and may be least prepared to think quickly and cope with others' reactions. Nonetheless, this must be done. With some advance planning, this process can be much smoother than if disaster takes you by surprise and no pre-formulated plan is in effect. Once a plan is in effect, adjustments can be made quickly to deal with the specific nature of the current crisis. When formulating a disaster plan, the following ideas may be helpful:

- Determine if your district is small enough to have a single crisis team or if separate building teams are needed, with an umbrella district team for times of widespread disaster.
- Team members should be selected on the basis of each member's expertise.
- Designate a team leader.
- Designate the disaster team or teams. This will likely include administrators, school psychologists, counselors, and other staff members without responsibility for individual classrooms.
- Designate an individual who will deal with the media. This is very important.
- Plan ways of using community resources and network with these agencies or individuals in advance. Potential resources include mental health agency personnel and clergy with special training in counseling.
- Prepare for weekend or after-hours meetings of disaster teams and coordinators, perhaps setting up a phone-tree for quick notification. Be sure to check contract language prior to requiring after-hours involvement, where necessary.
- Determine how PTO/PTA leaders might bring meals for staff members working late into the evening or arrange child care for staff members' children to free them for disaster team efforts.

All staff members should be aware of the disaster plan. Not only teachers, but clerical staff, aides, bus drivers, and maintenance staff need to be apprised of the plan. Including staff members in planning and sharing the plan at a district inservice day or teacher meeting allows time for discussion when stress and pressure are minimal. Another task that can be done in advance of disaster is preparing information on typical reactions to disasters and planning ways for distribution of such information. The teacher and parent handouts accompanying this information are designed for just such purposes. Pairing these handouts with one detailing events and resources in your community is suggested. Such a handout might include:

- Specific, factual information about the event
- Details about how the district is handling the crisis
- Information about contact people within the district including phone numbers
- Information about community resources including phone numbers
- Titles of books pertinent to disasters as well as books dealing with feelings. Ask librarians to use the bookfinder to prepare a list of such books available in your library (school and public) for a variety of topics (death, tornadoes, children and serious illness, etc.). This will facilitate quick access if the list is needed. Preparing such a list may suggest topic areas in which your libraries are weak and allow time for ordering additional materials.

Components of Effective Disaster Plans

Disaster plans can include steps to be taken immediately upon learning of a disaster as well as longer-term plans. The following items might be included:

Immediate Reaction to Disaster

- Determine how staff members and students will learn of the disaster. Provide accurate information to all concerned at approximately the same time to help control the spread of rumors. The PA system or messages to teachers might be used. depending on the nature of the disaster. A death or other intimate disaster may require a more personal manner of imparting information.
- Notify staff members in advance if time allows. Word of a death occurring over a weekend can be spread by phone or at an early-morning staff meeting.
- Target certain parents for special notification. For instance, if a member of an athletic team is killed, phoning parents of other team members might be indicated.
- Decide about scheduling changes: Decide whether to maintain normal schedules or set aside regular scheduling in an all-out effort to deal with the crisis. Obviously this decision will depend on the extent of the crisis and might even vary from grade to grade and from class to class. For instance, if a sophomore commits suicide, that class will probably need more assistance than the senior class. A most important step in any disaster is reopening the school and returning to a normal routine as soon as possible.
- Formulate plans for school dismissal: Typically keeping children in school for the regular school day is best when dealing with disaster. However, if early dismissal is required, parent notification becomes an item of priority.
- There may be occasions when an extended school day is necessary. For instance, if a shooting has occurred and the gunman/women is at large and most of the students walk home from school, dismissing students would be hazardous.
- Plans may need to be made for shielding children and staff from the media. Cordoning children as they are loaded into school buses may prove to be very effective for this purpose.

Intermediate Steps for Crisis Control

- Provide support and counseling for students. Regular instruction will probably need to be suspended while the disaster is discussed. Individuals trained in counseling might target classrooms for their most immediate services where children are most severely affected. Teachers need to know how to get assistance from another professional quickly should the need arise.
- Disseminate factual information about the crisis to parents. The most effective method of providing factual information to parents may be to prepare a letter to be sent home. Some parents may need to be contacted by phone, especially if their child's reaction to the disaster seems extreme.
- Decide how to deal with funerals or memorial services if death(s) are involved in the disaster. When possible, have parents take their own children to the services. If parents are unable to go, staff members may volunteer to do this. Permission slips may be needed. Successful suicides should not be treated as honored heroes in school assemblies and funeral attendance should, in most cases, be only with parents accompanying the children. At times, school buses may be used. Permission slips may be needed. Plans for make-up work or forgiveness for assignments not completed due to attending the services should be made and discussed with staff members so that a consistent plan is used.

Long-term and Ongoing Disaster Intervention

Provide for on-going opportunities to deal with the crisis. This might include:

- Continue to have additional support staff and outside professionals available to students.
- Make additional resources available to teachers who will be dealing with student reactions daily.
- Think ahead to effects which might be delayed. For example: A similar incident in another location may trigger renewed feelings.
- The one year anniversary of a disaster may provide an opportunity for planning a special remembrance, thereby diverting renewed reactions if the anniversary date is ignored.

Resources

Brooks, B. & Seigel, P. (1996). *The scared child: Helping kids overcome traumatic events.* New York: John Wiley & Sons.

Federal Emergency Management Agency (FEMA): FEMA Publications, PO Box 70274, Washington, DC 20024. (202) 646-3484.

Jozwiak, T., Johnson, C. & Petersen, E. (1995). Best practices in planning for emergency management within the schools. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology-III* (pp.397-402). Bethesda, MD: National Association of School Psychologists.

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Originally published by NASP (1992); resources updated 1998.

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Disaster: Helping Children Cope

A Handout for Parents

by Debby Waddell, Ph.D., NCSP, Columbus, OH
and Alex Thomas, Ph.D., NCSP, Miami University (OH)

Background

Disasters can take many forms. They may weather-related, as in tornadoes, hurricanes, or floods; accident-related, as in bus or automobile deaths or drowning; illness-related as in AIDS, cancer or other deaths due to illness; or bizarre and unusual, as in the case of snipers or a murder.

The emotional effects of a disaster on you and your child can be tremendous. One of the difficulties experienced by parents during disasters is that they have not had adequate time to deal with their own reactions when they are called upon to deal with the impact of the disaster on their child. This handout is designed to help you and your child during a disaster.

Reactions to Disaster

Common emotional reactions: Emotional reactions vary in nature and severity from child to child. Children's reactions to a disaster are determined by their previous experiences, their temperament and personality, and the immediacy of the disaster to their own lives. Nonetheless, some commonalities exist in how children (and adults) feel when their lives are disrupted by a disaster.

- *Loss of Control:* By their very nature, disasters are something over which we have no control — if we did, we would stop them from happening. The feeling of loss of control can be overwhelming.
- *Loss of Stability:* Disasters also interrupt the natural order of things. Stability is gone and this is very threatening; it can destroy trust and upset equilibrium for extended periods. After all, if this disaster could happen, then most anything else might happen too.
- *Self-centered Reactions:* Children's immediate reaction to disaster often includes a fear for their own safety. They may be intensely worried about what will happen to them, to an extent that you think is unreasonable. However, young children have difficulty putting the needs of others before their own. Children need repeated reassurance regarding their own safety and the outcome of the disaster as it relates to them.

Stages of reactions to loss. Some reactions to disasters are similar to reactions to other losses or grief. These include denial, anger, depression, bargaining and acceptance. Not every person experiences all of these feelings, and they do not always occur in just this order. A person may feel angry, then depressed, then angry again. How feelings are expressed will vary with the age of the child. A very young child may express denial by refusing to talk about the situation or clowning when others are talking about the disaster. Older children may go to their rooms or insist on going to the mall. Anger in a young child may involve a tantrum and in older child may be manifested as yelling at a parent.

Common stress symptoms: Following a disaster or traumatic crisis event, children — like adults — will likely exhibit at least several typical symptoms of stress, reflecting their emotional reactions and sense of loss. Symptoms tend to vary with the age and developmental maturity of the child. If symptoms persist for a long time or seem extreme, parents should seek professional help through the school or community healthcare provider. At different ages, parents can expect:

- *Preschoolers:* thumbsucking, bedwetting, clinging to parents, sleep disturbances, loss of appetite, fear of the dark, regression in toileting habits
- *Elementary school children:* irritability, aggressiveness, clinginess, nightmares, school avoidance, poor concentration, withdrawl from activities and friends, increased conflict with siblings
- *Young adolescents:* sleep disturbance, loss of appetite, poor school performance, physical complaints (headache, stomachache), conflict with parents, withdrawl from friends
- *Older adolescents:* sleeping and eating disturbances, agitation, lack of energy, lessened interest in peers, physical complaints (headache, stomachache), poor concentration, irresponsible or delinquent behavior

Supporting Children During or After a Disaster

Knowing what to say is often difficult. When no other words come to mind, a hug and saying, "This is really hard for us," will always work.

- *Try to recognize the feeling underlying your child's actions* and put it into words. Saying something like "It makes us mad to think about all the people and homes that were hurt by this hurricane," or "I can see you are feeling really sad about this," can help.
- Sometimes children may have an overwhelming fear that they are *unable to put into words*, and you may need to voice for them. For instance, if a friend loses his mother during a flood, you might want to say to your child, "You may be scared that something will happen to me and Daddy (or Mommy) too. We are safe, and the flood waters are leaving, so we aren't going to die from this flood."
- *Be honest* with your child about what has happened and what is happening.
- *Don't deny the seriousness of the situation.* Saying to a child "Don't cry, everything will be okay" does not reflect how the child feels and the child knows that, at least in the immediate future, this is not true.
- *Help your child know what words to use with others.* For instance, if the disaster has resulted in death, the child may feel overwhelmed about what to say to friends at the funeral home. You may need to help by suggesting some simple appropriate words.
- *Plan a practical concrete activity* to help children deal with feelings.
- *Involve children in decisions* about what to do to help restore their sense of having control in their lives. Possible activates include:
  - Collecting money for disaster victims.
  - Planting a tree as a memorial for a death.
  - Designing cards and writing notes to someone involved in the disaster.
  - Drawing pictures and putting up a bulletin board.
  - Writing poems or stories for a class book about the disaster.
- *Inform your children's teachers* about how they reacting and find out what is being done in the classroom to deal with the disaster.
- *Decide how to handle attending funeral* or memorial services if the disaster involves deaths. Whenever possible, parents should take their own children to services. Provide information about the funeral and its structure to prepare children for the experience. Children who aren't going may still want to know what will happen. For young children, this may be their first experience with death, and information may be especially important for them.
- *Allow for the fatigue* which children may experience due to stress and changed sleep patterns.

Long-term Reactions

Prepare for long-term reactions which are normal, such as the continued need to discuss a hurricane or shooting.

Be alert for pathological long-term reactions, which are more severe than those experienced by most children. These might include (1) persistent reexperiencing of the traumatic event through intense recollections, dreams, flashbacks or hallucinations, (2) persistent avoidance of stimuli associated with the trauma or numbing of responsiveness — restricted affect, diminished interest in usual activities or (3) signs of increased arousal, such as sleep difficulties, irritability, hypervigilance, disturbances in concentration, or exaggerated startle response.

Find ways to emphasize a return to stability. When the disaster abates, return to previous schedules and maintain these for a time, even if some change in routine was planned, in order to provide a sense of security and comfort.

Resources

Brooks, B. & Seigel, P. (1996). *The scared child: Helping kids overcome traumatic events.* New York: John Wiley & Sons.

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Originally published by NASP (1992); additional material and resources added by Andrea Canter, Ph.D., NCSP (Minneapolis Public Schools)

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Disaster: Helping Children Cope

A Handout for Teachers

**by Debby Waddell, Ph.D., Columbus, OH
and Alex Thomas, Ph.D., Miami University (OH)**

Background

Disasters can take many forms. They may weather-related, as in tornadoes, hurricanes or floods; accident-related, as in bus or automobile deaths or drowning; illness-related as in AIDS, cancer, or other deaths due to illness; or bizarre and unusual, as in the case of snipers or a murder.

Pre-planning can be done for some of these disasters, as when a death from cancer is anticipated or when weather forecasts warn of hurricanes. Others may be sudden and allow no time for pre-planning. Yet another variable is whether the disaster occurs at school, such as a suicide in the school or tornado during school hours, or outside of school hours, such as a hurricane or automobile accident. All of these factors will undoubtedly affect the specific response to the disasters, but some common elements can be found in responses to all of these situations.

Teachers have two essential jobs in the aftermath of disasters: First, to make plans for the practical aspects of how the disaster will be handled in their own classroom and second, to understand and cope with student reactions. The first of these responsibilities will likely be shared with other building personnel, but each teacher will have to structure the response within his/her own classroom. The second responsibility, coping with student reactions, again will be shared, this time with the parents and individuals such as school psychologist, school counselor or an outside mental health professional. The ongoing need to deal with student reactions during the school day, however, will fall on individual teachers. Determining appropriate steps to be taken immediately upon experiencing a disaster and deciding what to do in the days and weeks that follow is crucial.

Student Reactions to Disaster

Common emotional reactions: Emotional reactions vary in nature and severity from student to student. Children's reactions to a disaster are determined by their previous experiences, their temperament and personality, and the immediacy of the disaster to their own lives. Nonetheless, some commonalities exist in how students (and school staff) feel when their lives are disrupted by a disaster.

- *Loss of Control:* By their very nature, disasters are something over which we have no control—if we did, we would stop them from happening. The feeling of loss of control can be overwhelming.
- *Loss of Stability:* Disasters also interrupt the natural order of things. Stability is gone and this is very threatening; it can destroy trust and upset equilibrium for extended periods. After all, if this disaster could happen, then most anything else might happen too.
- *Self-centered Reactions:* Children's immediate reaction to disaster often includes a fear for their own safety. They may be intensely worried about what will happen to them, to an extent that adults think is unreasonable. However, young children have difficulty putting the needs of others before their own. Children need repeated reassurance regarding their own safety and the outcome of the disaster as it relates to them.

Common stress symptoms: Following a disaster or traumatic crisis event, students—like adults— will likely exhibit at least several typical symptoms of stress, reflecting their emotional reactions and sense of loss. Symptoms tend to vary with the age and developmental maturity of the child. If symptoms persist for a long time or seem extreme, teachers should consult their building mental health staff (school psychologist, counselor, social worker) and discuss concerns with parents. Professional help through the school or community healthcare provider might be needed, At different ages, teachers might observe:

- *Elementary school children:* irritability, aggressiveness, clinginess , school avoidance, poor concentration, withdrawl from activities and friends, increased conflict with peers. Parents might report concerns about sleeping difficulties, including nightmares.
- *Young adolescents:* poor school performance, physical complaints (headache, stomachache), withdrawl from friends. Parents might report concerns about sleep disturbance, loss of appetite and conflict between parent and child.
- *Older adolescents:* agitation, lack of energy, lessened interest in peers, physical complaints (headache, stomachache), poor concentration, irresponsible or delinquent behavior. Parents might report concerns regarding sleeping and eating disturbances.

What Can Teachers Do? Immediate Responses

Inform students of the disaster: Typically some school-wide decision is made regarding notification of staff and students. Often the PA system or a message to all teachers is used so the same information is given to everyone at the same time and the spread of rumors is controlled. A death or other intimate event may require a more personal method of imparting information.

A teacher's responsibilities include:

- Ensuring that the information your students receive is appropriate to their developmental level and is stated in vocabulary they can understand. You may need to restate information in several ways so that every student understands.
- Controlling panic among your students. Your calm demeanor and take-charge attitude can do much to control panic. It is okay for students to know that you are upset, for instance by shedding tears over a death. While it will be natural for you to experience emotion, it is important to students that you maintain composure and control of the situation.

Decide about scheduling changes: Decisions about scheduling changes may be made by administrators. However you will have to make decisions about what is to happen in your classroom.

- Generally, returning to a normal routine is appropriate.
- If students seem very unsettled, returning to a normal routine may not be the best choice. Possible immediate responses to disaster include discussing what has happened, clarifying information and facts, and listening carefully.

Intermediate Steps for Crisis Control

Arrange support and counseling for students: Building administrators will probably have made arrangements for support services. Your job is to know how, where, and when to access these services and to channel students in need of these services to the appropriate individuals.

Children particularly affected by the disaster should be carefully observed. They may require extra support and assistance.

Continue to have group discussion time at the beginning of the day. This may be useful in clearing the air of rumors and helping the students get ready for school work.

Plan a practical concrete activity to help student deal with feelings: Involve students in decisions about what to do to help restore their sense of having control in their lives. Possible activities include:

- Collective money for disaster victims.
- Planting a tree as a memorial for a death.
- Designing cards and writing notes to someone involved in the disaster.
- Drawing pictures and putting up a bulletin board.
- Writing poems or stories for a class book about the disaster.

Inform parents about how their children are reacting and what is being done in the classroom to deal with the disaster. A handwritten, dittoed note will suffice in this situation.

Decide how to handle attending funeral or memorial services if the disaster involves deaths. Whenever possible, have parents take their own children to services. If necessary, arrange transportation for a student to a memorial service. If you will be teaching during the service, a parent or another staff member may take the student. (Permission slips may be needed.) The person chosen should be prepared to deal with the student's emotional reaction to the service.

Provide information about the funeral and its structure to prepare the students for the experience. Students who aren't going may still want to know what will happen. For young children, this may be their first experience with death, and information may be especially important for them.

Allow for the fatigue which children may experience due to stress and changed sleep patterns.

- Plan for less intense instructional activities for a few days.
- Introduce snack time for a few days to provide extra nourishment which tired children may need. Room parents or the PTA/PTO may be willing to provide snacks.
- Delay tests which will allow fair evaluation of student performance after stress levels are reduced.

Long-term and Ongoing Intervention

Provide ongoing opportunities to deal with the crisis:

- Let students know there continue to be people available who are willing to listen. Tell them who is available and when and where to find these people.
- Discuss feelings with the entire class or individual children who feel most affected.
- Discuss the disaster in the context of other subjects, e.g. discuss suicide prevention in a junior high health class, discuss weather-related disasters in elementary social studies class.

Provide facts to help allay fears: For instance, if a classmate dies of cancer, facts about prevalence and cures may help students who are fearful when they feel unwell.

Think ahead to effects which might be delayed: For instance:

- Be aware that similar incidents in another location may trigger renewed feelings.
- Plan a special remembrance for the one-year anniversary of the disaster, thereby diverting renewed reaction if the anniversary date is ignored.

Listen and watch for long-term reactions:

- Prepare for long-term reactions which are normal, such as the continued need to discuss a hurricane or shooting.
- Watch for pathological long-term reactions. Pathological long-term reactions are more severe than those experienced by most children and might include (1) persistent reexperiencing of the traumatic event through intense recollections, dreams, flashbacks or hallucinations; (2) persistent avoidance of stimuli associated with the trauma or numbing of responsiveness, such as restricted affect, diminished interest in usual activities; or (3) signs of increased arousal, such as sleep difficulties, irritability, hypervigilance, disturbances in concentration, exaggerated startle response.

Find ways to emphasize a return to stability: When the disaster abates, return to previous schedules and maintain these for a time, even if some change in routine was planned, in order to provide a sense of security and comfort.

Resources

Brooks, B. & Seigel, P. (1996). *The scared child: Helping kids overcome traumatic events.* New York: John Wiley & Sons.

Pitcher, G. & Poland, S. (1992). *Crisis intervention in the schools.* New York: Guilford Press.

Robinson, E., Rotter, J., Fey. M. & Vogel, K. (1992). *Helping children cope with fears and stress.* ERIC/CAPS (ERIC Counseling and Professional Services Clearing House).

Originally published by NASP (1992); additional material and resources added by Andrea Canter, Ph.D., NCSP (Minneapolis Public Schools), 1998.

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Emotional First Aid

A School's Guide to Crisis Intervention

by Servio Carroll, Ed.S., NCSP, Crisis Intervention Team
Sheridan (WY) School District No. 2

Overivew

A crisis happens when one's coping mechanisms are overwhelmed by a situation. This inability to cope is a potentially dangerous situation because, as our stress levels rise, our excitability and impulsivity increase and our coping mechanisms and behavior options sharply decrease. Crises usually happen following large changes or losses in a person's life. Potential crisis situations are separation from meaningful relationships (like in death or divorce), flunking out of school, moving to a strange town, birth of a new child in the family, loss of security, loss of freedom, etc. Crises are normal occurrences in everyday lives and most people experience and successfully cope with these situations. The experience strengthens one's ability to handle future similar situations.

The ability to help people in distress is not the exclusive property of mental health professional. We have been successfully dealing with crises (both our own and our acquaintances') for many years, and have developed useful ways of dealing with these situations. Since in most cases we will encounter the distressed individual long before "professional" help is available, this Guide was created to give you the basics of Emotional First Aid. Don't be surprised if you find that some of the suggestions sound like "common sense."

Helping the Individual in Crisis

People in crisis act differently than normal. Depending on the crisis event and their coping ability, the changes may come about slowly, suddenly or be delayed. If you know the person in crisis, you will recognize they are not acting as usual, but be unsure as when to intervene. Most of us find this intervention uncomfortable and shy away from the person, with a wealth of rationalizations. Whether this is right or wrong, it's culturally accepted. However, shying away is much more difficult to do when an unexpected and sudden event takes place. ...and you are there! So what can you do to help bring equilibrium to the situation and help others regain their emotional balance?

1. **Make Contact.** It is important to make physical or emotional contact with the person in crisis. Depending on your relationship with the person, you might touch, shake or hold their hand, make eye contact, offer or accept a soda, cup of coffee, etc.
2. **Suspend Judgment.** When trying to understand the person in crisis it is helpful to listen in a special way — that is listening without judging or placing expectations on the person. Since the person may be afraid of gossip, assure him that what is discussed will remain confidential. Some questions you might be asking yourself are: How does the person actually handle a crisis? Whom does she usually go to? What kind of supports does he have?
3. **Clarify the Problem.** People in crisis are often so nervous and disorganized that they are unable to be objective and define what the problem is. You may be able to help clarify the problem.
4. **List Choices.** A person in distress is often unable to see the alternatives available. You may be able to help the person list specific options available.

5. **Encouragement.** Sometimes a person in crisis will be "stuck" or "spinning their wheels," unable to make any progress. He might need encouragement to take some kind of action or to make a decision that would start the coping process again. This does not mean that you should make decisions for other people but that the person in crisis may need a little push to make her own decision.
6. **Give Information.** One of the most important services you can provide to many people is information on resources available in the community. Information about visiting nurses, legal aid, food cooperatives, YMCA, YWCA, social clubs, welfare, etc. if often unknown to many people. You can act as a link or advocate to these resources.

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Resources for Safe Schools

Compiled by Rhonda Broadwater, NCSP, Chair
NASP Continuing Professional
Development Committee

Brookline Books

(P.O. Box 1047, Cambridge, MA 02238)

The Cognitive Strategy Instruction that Really Improves Childrens' Academic Performance — 2nd Edition

Cognitive Strategy Instruction for Middle and High Schools

Strategies and Self-Regulation in the Writing Process Classroom

Helping Students Become Strategic Learners

Making School Inclusion Work

Teaching Students Ways to Remember Strategies for Learning Mnemonically

Teaching Test Taking Skills

Multicultural Issues in the Education of Students with Behavioral Disorders

Enabling and Empowering Families: Principles and Guidelines for Practice

Developing Individualized Family Support Plans

Deciphering the System: A Guide for Families of Young Children with Disabilities

Positive Adolescent Choices Training: A Model for Violence Prevention Groups with African American Youth

CPPC

(4 Conant Square, Brandon, VT 05733)

Preparing for Crises in the Schools: A Manual for Building School Crisis Response Teams

Educational Horizons

(PO Box 25739, Eugene, OR 97402)

Picture the Progress

Multigrowth Resources

(12345 Jones Rd. #10, Houston, TX 77070)

Teach and Reach Students with Attention Deficit Disorders

NASP Publications

(4340 East West Highway, #402, Bethesda MD 20814)

Understanding and Managing Childrens' Classroom Behavior
Behavior Change in the Classroom: Self-Management Interventions
Helping Children Cope with Fears and Stress
Student Aggression: Prevention, Management, and Replacement Training
Anger, Hostility, and Aggression: Assessment, Prevention, and Intervention Strategies for Youth
Student Self-Esteem: A Vital Element of School Success
Alternative Educational Delivery Systems: Enhancing Educational Opportunities for All Students
Home-School Collaboration: Enhancing Childrens' Academic and Social Competence
Interventions for Achievement and Behavioral Problems
Best Practices in School Psychology-III
Crisis Intervention in Schools
Curriculum-Based Measurement: Assessing Special Children
Academic Skill Problems: Direct Assessment and Intervention
Reading Problems: Consultation and Remediation
Designing Interventions for Preschool Learning and Behavior Problems
Peer Tutoring: A Guide for School Psychologists
Resources in Crisis Intervention: School, Family, and Community Applications
Youth Suicide: A Comprehensive Manual for Prevention and Intervention
The EQUIP Program: Teaching Youth to Think and Act Responsibly Through a Peer-Helping Approach
Helping Children at Home and School: Handouts from Your School Psychologist

Research Press

(PO Box 9177, Champaign, IL, 61826)

I Can Problem Solve
Skills and Techniques for Group Work with Children and Adolescents
Break It Up: A Teachers' Guide to Managing Student Aggression
Break It Up: Managing Student Fights (video)
What Growing Up Is All About: A Parents' Guide to Child and Adolescent Development
Viewpoints: A Guide to Conflict Resolution and Decision Making For Adolescents
The EQUIP Program: Teaching Youth to Think and Act Responsibly Through a Peer-Helping Approach
When Your Child is Difficult
Skillstreaming Series
How to Create Positive Relationships with Students
Creating the Peaceable School: A Comprehensive Program for Teaching Conflict Resolution
Skills for Living: Group Counseling Activities for Elementary Students and Young Adolescents
Peer Mediation: Conflict Resolution in Schools

Sopris West

(1140 Boston Ave., Longmont CO 80501)

Tough Kid Book: Practical Classroom Management Strategies

Tough Kid Tool Box

Tough Kid Social Skills Book

The Acting Out Child: Coping with Classroom Disruption

Village Press

(P.O. Box 2496, Carmel Valley, CA 93924)

The Student Study Team Survival Guide

Western Psychological Services

(12031 Wilshire Blvd., Los Angeles, CA 90025)

Handbook of Individualized Strategies for Classroom Discipline

Parent-Child Relationship Inventory

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Suicide in Children and Adolescents

Information for Parents

by William O. Hahn
Behavior Management Consultants, New Kensington, PA

Background

It is estimated that a child or adolescent will commit suicide every 90 minutes. Suicide among individuals age 15-24 is the third leading cause of death. Research indicates that over 60% of all high school students contemplate suicide at some time during the school year, while 8-13% engage in suicidal behavior. From 1980-1992, the rate of suicide among 10-14-year-olds increased 120%. Add to these statistics those children who attempt suicide and we have a problem of almost epidemic proportions.

Development

While suicide is considered to be a uniquely individual act, there are some common trends and identifiable traits. Children as young as 2 or 3 may attempt suicide, but they do not usually utilize a lethal method. Even children between the ages of 6 and 10 tend not to use lethal methods. This seems due to the fact that younger children are almost "protected" from self-destruction by virtue of their immaturity. A common factor present in suicidal young children, which tends to prevail even into adolescence, is a strong sense of abandonment or rejection by a significant other. As children become older stress factors may intensify and add to the problem. Significant stressors such as addition of a third party to the family, sibling birth, parental divorce, and as was mentioned, a sense of abandonment all play an important part. Losses such as these often result in a decrease in self-esteem and an increase in anger or rage. Thus suicide for the child becomes either an attempt to alter an intolerable situation, a cry for help, or a means of gaining attention, love, and affection from significant others. Suicide rates are particularly high among gay teenagers, reflecting the rejection they may feel or anticipate from family and peers and sense of isolation.

In adolescence, suicidal behavior is related to the following risk factors:

1. Loss of significant other
2. Recent suicide of a peer or family member
3. Legal difficulties
4. Unwanted pregnancy
5. Family stress (including divorce, separation, unemployment)
6. Recent and/or frequent changes in school
7. Difficulties in relationships
8. Depression and withdrawal
9. Disorientation and isolation, psychiatric disorders
10. Substance abuse
11. Poor school performance

As with younger children, these teenagers often find themselves in what they consider to be an intolerable situation. Unfortunately, they become rigid in their thinking, unable to see any alternatives other than suicide. Often there are prevailing feelings of hopelessness, (that is, the feeling that there is no hope, and that the future looks bleak). With these types of views, and an inability to see alternatives, the child's only solution becomes a suicide.

Five danger signs of suicide:

1. A suicide threat or statement indicating a desire to die
2. A previous attempt
3. Severe depression
4. Marked changes in personality or behavior
5. Making a will or giving prized possessions away

What Can I Do as a Parent?

It is important for the parents to be aware of his/her child's moods, feelings and attitudes. *Sudden mood swings* or *marked changes in behavior, decreasing grades* and/or *withdrawal from friends* often signify the onset of depression. The parent must realize that this is often not just a "phase" that the child is going through, but indications of a problem. Of primary importance in helping these distressed children is letting the child know that no matter what, you are there as a parent to help them, that you care for them, and love them. While you might not be able to heal their pain, resolve their problems, or even understand what they are going through, you must let them know that you are willing to listen and help them in whatever way possible.

As a parent, if you begin to notice signs of depression, or more importantly, signs of suicidal behavior, you should begin by talking with your child. Let him or her know that you will listen, and that you are not going to judge him. Encourage her to express her feelings and really listen. Try not to criticize or downplay his feelings. At some point, it will become necessary to ask him if the has thought about suicide. (You are not putting an idea into her heads—the majority of children and adolescents know what suicide is, so you are not giving them any suggestions.) If she has seriously thought about suicide, then it is time to seek professional help, either through the school, local mental health agency, private agency, suicide hotlines or your family physician. If, in addition to the suicidal thought, the child has a plan of suicide, then serious consideration should be given to hospitalization of the child for her own protection. Any time that you fear that your child might be suicidal, it is imperative that you seek the help of qualified professionals. It is also advisable that you remove any guns from the house, as this is the most lethal of all methods, and also one that is prone to be used impulsively.

After the suicidal crisis is over, you must continue to support, listen, and care for your child. You don't want him to think that he must threaten suicide in order to get your attention. It is also important to follow-up with a mental health agency, in order to resolve the difficulties that stimulated the suicidal behavior. Remember, youth suicide is a family problem.

Resources

Brooks, B. & Seigel, P. (1996). *The scared child: Helping kids overcome traumatic events.* New York: John Wiley & Sons.

Martin, M. & Waltman-Greenwood, C. (1995). *Solve your child's school-related problems* (Appendix B: Helping your child through crisis at home and at school). New York: HarperPerenniel.

Organization

American Association of Suicidology, 2459 S. Ash, Denver CO 80222; (303) 692-0285

Websites

San Francisco Suicide Prevention: *<http://www. Sfsuicide.org/things/html>*
[Offers a variety of information including a suicide risk evaluation tool]
Wings of Madness Suicide Resources:<http://bobbyt.simplenet.com/stuff/depress/suicide.htm>
[Webpage for SA/VE— Suicide Awareness/Voice of Education.]

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Suicide Intervention in the Schools

A Handout for School Personnel

by Scott Poland, Ph.D.
Cypress-Fairbanks ISD, Houston, TX

Incidence

The problem of youth suicide has dramatically increased in recent years: 300% since 1950; 200% since 1970; since 1982, the rate among 10-14-year-olds has increase over 120%. Adolescents are especially at risk, and gay adolescents at very high risk. Recent surveys of high school students indicate that over 60% have seriously thought about suicide and 8 to 14% have engaged in suicidal behavior. Suicide is the third leading cause of death for adolescents and young adults, with approximately 100 to 120 attempts for every death.

The suicide of elementary age students is rare with less than 200 suicides occurring annually. Young children have less thought-out plans, have a limited understanding of death, and may engage in reckless behavior.

Role of the School

- To detect suicidal students
- To assess the severity level of suicidal risk
- To notify the parents of the suicidal student
- To work with the parents to secure the needed supervision and services for the student
- To monitor the student and provide on-going assistance

Warning Signs

Everyone should know the following warning signs of suicide and the referral procedures to follow to assist the student:

- Suicidal threats
- A previous attempt at suicide
- Prolonged depression
- Dramatic change of behavior or personality
- Making final arrangements (giving things away, putting things in order)

Confidentiality

No one should keep a secret about suicidal behavior. The parents of the suicidal student must be notified. School districts and their employees have been sued for failing to notify parents, inadequately supervising and failing to get psychological help for suicidal students. The liability issues are foreseeability and negligence.

Empowerment

All school employees play a role in preventing youth suicide. Listen and hear what the student is saying. Trust your judgment and inquire directly, openly and honestly about the student's suicidal thoughts. Take definite action to get help for the student.

Key Myths Debunked

Suicide is not inherited. It is not someone's destiny. There are many people alive today who were suicidal at one time. Young people are often ambivalent about suicide and go back and forth between wanting to live and wanting to die. The young person who talks or writes about suicide may be at risk and cannot be ignored.

Factors and Forces in Youth Suicide

Researchers have identified as many as 28 different causes. There is no one type of young person that is more at risk. The following factors are involved in many youth suicides:

- Depression
- Drug and alcohol usage
- Angry and rebellious behavior
- Gun availability
- Impulsive and reckless behavior

Assessment

School employees such as counselors and psychologists should have special training to determine the severity risk level for a suicidal student. "No suicide contracts" should be utilized to gain a promise from the student not to follow through on his or her suicidal plans. Alternatives to suicide should be emphasized.

Getting Assistance for Suicidal Students

Community services such as crisis hotline centers, hospitals and private practitioners are available to assist. Parents need to be encouraged to reach out to their child through increased supervision and communication. Parents need to take suicidal threats seriously and professional help must be sought whether or not the child's behavior is manipulative. It may be necessary to document in writing that parents were notified and encouraged to get assistance in the community. School personnel should continue to monitor and assist the student.

Curriculum

There is a debate about the advisability of classroom presentations on suicide prevention. A presentation that is well integrated with a mental health unit is recommended. The information presented must also emphasize friend intervention and prevention. All information presented should be carefully selected.

Postvention

Few events are more scary than the suicide of a student. Care should be taken not to glorify the student. Memorials should be downplayed. The suicide of the student must be acknowledged and students must be allowed the opportunity to express emotions and ask questions. This discussion should be done in either small groups or a classroom format but not in an assembly. Networking counseling efforts should assist the friends of the deceased to manage their grief and should assist other students previously known to be suicidal.

Media

Coverage should be downplayed. Back page coverage if any at all is preferred. Suicide should not be portrayed as mystic, romantic, simplistic or unexplainable. Details of the method should be avoided. Emphasis should be placed on where suicidal students can get help.

Resources

Brock, S. & Sandoval, J. (1997). Suicidal ideation and behaviors. In G. Bear, K. Minke & A. Thomas (Eds.), *Children's needs II: Development, problems and alternatives* (pp. 361-374). Bethesda, MD: National Association of School Psychologists.

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Organization

American Association of Suicidology, 2459 S. Ash, Denver CO 80222; (303) 692-0285.

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Victimization of School-Age Children

Safe Schools Strategies for Parents and Educators

by Gloria E. Miller and Kelli A. Rubin, University of South Carolina
revised by Servio Carroll, Ed.S., NCSP, Sheridan (WY) School District No. 2

Definition of a Victim

A victim is a child who has directly or indirectly suffered as the result of isolated or repeated confrontations or personal violations by another child. Primary victims suffer the physical and affective consequences of direct assaults. Secondary victims experience indirect affective reactions as a result of witnessing or hearing about a victimization incident.

Modes of Victimization in School Settings

There are three common modes of personal victimization of students by their peers in school settings, excluding more severe personal crimes such as homicide and rape:

- Violations of Body — fighting and other physical assaults
- Violations of Esteem — bullying, ridiculing, teasing, threatening
- Violations of Property — confrontive and nonconfrontive theft or damage to items from lockers, desks, bookbags, lunches

Key Myths About Victims

- ***Victims stand out in some way.*** Victims do not significantly deviate in behavior, appearance, or ability from non-victims with the possible exception of having less physical strength.
- ***Girls are victims more often than boys.*** Both sexes are equally vulnerable for victimization; however, peers nominate boys as victims more often than girls.
- ***Victims are all alike.*** Victims are not homogeneous. Olweus describes at least two types of child victims: "Passive Victims" — anxious, insecure, seemingly do nothing to invite attacks, and fail to defend themselves; "Provocative Victims" — hot-tempered, restless, create tension by irritating and teasing others and fight back when attacked.

Some Facts About Victimization

- Approximately one in ten school children will experience some mode of victimization during their school years.
- In any one-month period, many students will avoid three or more school locations or miss a day of school out of fear of being assaulted.
- In the majority of victimization incidents, the victim knows the offender's name.
- Victimization occurs in both supervised (e.g., classrooms) and unsupervised (e.g., playground) areas with more serious assaults in the latter settings.
- Incidents of property violations tend to occur at a higher rate than physical violations.
- Physical victimization rates tend to decline after the elementary grades, while verbal assaults remain high at all grades, and property violations show little change across grade levels.
- Children who are victimized in one mode tend to be victimized more often in other modes.
- The likelihood of repeated victimization increases when a child has been previously victimized.
- By the time a child reaches middle school, a pattern of victimization has often been established.

Why Focus on the Victim?

Victimization may be a catalyst for other problems. Victimization often results in peer rejection which has been linked to later behavior problems, delinquency school dropout, depression and even suicide. Unpopularity with peers ultimately affects the development of close interpersonal relationships.

Victimization incidents are likely to be repeated without intervention. Students who are victimized once are much more likely than others to be victimized again. A progression of victimization has been noted whereby a student is victimized more severely as the oppression continues. The stigma of being labeled a "victim" also makes it difficult to recover and consequently furthers the cycle of victimization.

Victimization has detrimental indirect effects. Indirect affective reactions, like fear and anxiety, that occur as a result of victimization can lead to school avoidant behaviors. Ultimately, these affective responses negatively influence the school's social climate, leading students to distrust authority figures and become disillusioned about the school system.

Victimization has not been adequately addressed in schools. There is a prevailing focus on the perpetrators of assaults. Often the role of the victim and the victim's needs are disregarded, decreasing the likelihood that victims will be helped to regain a sense of control or learn effective deterrent strategies.

Victimization prevention is based on knowledge of the entire process. Typically, less attention is given to the victim's role in the transactions that affect antisocial behavior. Yet such information is critical to future prevention and intervention efforts designed to alleviate school crime and violence.

What Can Be Done? Suggestions for Schools

- A first step is to target the problem by facilitating accurate and timely reports of victimization — possibly through anonymous hotlines or maildrops.
- Improve safety and enhance deterrence through modifications in the physical setting (e.g., alter exit and entry areas; increase lighting in dark, less traveled or secluded areas) or improved surveillance measures (e.g., videotape recorders; student hall monitors; parent volunteers on the routes to and from school).
- Find ways to create a small school atmosphere even in a large school environment thereby increasing student/faculty face-to-face contact and enhancing trust between the two groups.
- Construct a school creed that clearly identifies individual rights and places value on cooperation and compromise.
- Work with students, school staff and community members to develop explicit firm and fair rules against repeated physical and mental maltreatment that clearly prohibit violations of body, self-esteem and property.
- Provide counseling services and other system-wide opportunities that foster open communication about victimization incidents for students, school professionals and parents.
- Recognize the importance of varied curriculum goals that provide vocational as well as academic options in order to allow the students to feel worthy in their choice of futures.
- Review grading and evaluation procedures to avoid assigning students to "failure" roles that often lead to higher frustration levels increasing the likelihood of incidents of aggression.
- Ensure that students have a negotiation procedure that allows for mediation and conflict resolution such as a pear review board. This allows students to vent their anger while letting them view the other side of the conflict.
- Develop a systematic inservice and staff development plan to increase sensitivity and knowledge about the reciprocal process of victimization, prevention and intervention strategies.

Suggestions for Teachers

- Assess personal attitudes about victimization so as to avoid possible stigmas and judgments that arise when a child is labeled as a victim.
- Capitalize on students' strengths rather than focusing on weaknesses to enhance their self-esteem.
- Reestablish the victims sense of control as soon as possible by involving them in the decision making process as what to do next after the incident.
- Appoint the victims added responsibilities and delegate them leadership roles to improve their status, self-assurance and social skills.
- Assign cooperative classroom projects that necessitate group goals, collaboration and teamwork and involve the aggressor and the victim as pair-mates.
- Establish extended avenues for open home-school communication that serve to highlight both positive and negative happenings in a child's life, possibly through shared notes, diaries or routine phone contacts.
- Initiate classroom discussions of interpersonal conflicts that identify precipitating events from the perspective of both the perpetrator and the victim and lead to alternative problem resolution strategies.
- Discuss the significance of the judicial system and the personal, community and societal consequences of crime to increase students' awareness of the averse effects of violence.

Suggestions for Parents

- Be aware of abrupt changes in your child's behavior that may indicate repeated victimization (e.g., fears or dislike of school, missing personal belongings).
- Do not overreact or question if your child mentions a victimization incident; listen actively so he or she will feel comfortable discussing the problem further. Restate the content of his or her statements and add a comment that identifies their unstated feelings or reactions (e.g., "So, Jon hit you when you walked to the gym for no reason — that must be very upsetting.")
- Praise your child when you observe examples of appropriate social behaviors, such as sharing, in order to improve his/her self-confidence and to teach new ways to resolve conflict.
- If your child is a victim, jointly decide with him or her what to do as a next step so as to reestablish a sense of control to the victim.
- Keep well informed about your child's school environment to establish a greater sense of security in your child.
- Become an advocate for school safely by working as a team player with the school staff to guarantee your voice is heard and ideas are expressed.
- Arrange for increased monitoring and limit the unsupervised time your child has at school through collaboration with school personnel.

Resources

Baenninger, R. (Ed.). (1991). *Targets of violence and aggression.* Holland: Elsevier Science Publishers.

Batsche, G. (1997). Bullying. In G. Bear, K. Minke & A. Thomas (Eds.), *Children's needs II: Development, problems and alternatives* (pp.171-180). Bethesda, MD: National Association of School Psychologists.

Garrity, C., Jens, K., Porter, W., Sager, N. & Short-Camilli, C. (1994). *Bully-proofing your school.* Longmont, CO: Sopris West.

Goldstein, A.. Palumbo, J., Striepling, S. & Voutsinas, A. *(1995). Break It Up: A Teachers' Guide to Managing Student Aggression.* Research Press. [video also available]

Goldstein, A., Jarootunian, B., & Conoley, J. (1994). *Student aggression: Prevention, management and replacement training.* New York: Guilford.

Martin, M & Waltman-Greenwood, C. (Eds.) (1995). *Solve your child's school-related problems.* New York: HarperPerenniel.

Olweus, D. (1993). *Bullying at school: What we know and what we can do.* Cambridge, MA: Blackwell.

Ross, D. (1996). *Childhood bullying and teasing: What school personnel, other professionals and parents can do.* American Counseling Association.

Organizations

National Crime Prevention Council — 1700 K St NW, Second Floor, Washington, DC 20006; (202) 393-7141. [curriculum materials; neighborhood and community programs]

National School Safety Center — 4165 Thousand Oaks Blvd., # 200, Westlake Village, CA 91632; (805) 373-9977. [written and video materials available]

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Asperger's Disorder

Handout for Teachers and Parents

Children with
Special Needs

**by Alison Rifkin Westerkamm
and Jane Holtsclaw Fox
East Central (IN) Special Services**

Background

Asperger's Disorder (AD) is a pervasive developmental disorder characterized by deficits in social interaction, adherence to rules, routines and rituals, and lack of emotional reciprocity. It is generally equated with high functioning autism; the primary distinction is that people with autism exhibit a significant delay in language skills while those with AD have only mild impairments or peculiar ways of using language. Both autism and AD include problems with social interaction skills and interests which are limited in scope and structure. Children with AD often display clumsiness with fine and gross motor activities, although this characteristic is not necessary for a diagnosis. They typically have intellectual abilities ranging from the average to the superior range of functioning.

AD is more likely to occur in males and research studies have estimated that between 20 and 40 per 10,000 people meet the diagnostic criteria for AD. People with AD often have such coexisting problems as tic disorders, attentional disorders or mood disorders.

Key Characteristics

- ***Social interaction:*** socially aloof, inappropriate eye contact, typically desire interaction with peers but are unskilled in approaching or sustaining positive interaction; specifically have difficulty taking the perspective of another person and appear to lack empathy
- ***Rules/Routines/Rituals:*** use objects in atypical fashion (e.g., continually lining up toy cars but not "driving" them), insisting that others do things according to a strict structure developed by their own rules, strong desire for orderliness
- ***Language development:*** may have delays in early childhood followed by a "language explosion" with rapid skill acquisition; may demonstrate hyperlexia (an extraordinarily broad vocabulary) but not understand language usage or pragmatics; may engage in perseverative or repetitive speech; impairments in social uses of language and deriving meaning from spoken or written word
- ***Poor problem solving and organization skills:*** difficulties in situations requiring "common sense," organization and abstract reasoning; deficits in mental planning, impulse control, self-monitoring and transitioning from one situation to another
- ***Limited interests and preoccupations:*** may talk at length about some topic of interest only to him/herself
- ***Motor clumsiness:*** seen primarily at the preschool level, may have visual-motor deficits similar to those of people with learning disabilities

Diagnosis

Many students with AD will be undiagnosed or misdiagnosed. Common early diagnoses include autism, a specific learning disability or obsessive-compulsive disorder. Teachers should report symptoms to the child's parents; parents should seek referral to a mental health professional competent in assessment of psychiatric disorders (i.e., school psychologist, psychiatrist, mental health counselor, clinical psychologist). The assessment should systematically rule out other disorders and determine the possibility of medical intervention, special education programming and therapy. Assessment should include a measure of cognitive ability, academic achievement, speech/language functioning and social/emotional functioning. A comprehensive developmental and family history should be included, as well.

How Can Parents and Teachers Help?

Although children with AD have similar characteristics, their educational needs may differ. An individual plan, either under IDEA (Special Education) or Section 504 (accommodations for individuals with disabilities), is recommended. Communication between school and home will also be an important factor in the student's success.

Academic Interventions

- Consistency is essential: Provide a safe and predictable environment where transitions can be minimized; provide a consistent daily routine; prepare AD student for changes in routine and new activities.
- Provide assistance for the student with AD as soon as difficulties are noted. These children are quickly overwhelmed and react much more severely to failure than most other children.
- Emphasize these individuals' exceptional memory; they are typically quite able to retain factual information.
- Do not assume that children with AD understand something just because they can repeat what they have heard. Use brief, concise instructions. Offer added explanation and try to simplify or make new concepts more concrete than abstract.
- The student with AD needs great motivation to not follow his or her own impulses. Learning must be made a rewarding experience and not one that induces anxiety in the student with AD.
- Children with AD generally have excellent reading recognition skills but difficulties with comprehension. Do not assume they have understood what they easily decoded.
- If the student demonstrates visual-motor difficulties, modify expectations and demands for written assignments (e.g., shorten the assignment or provide more time for completion, allow the student to respond orally or into a tape recorder).
- Students with AD require a learning environment in which they see themselves as competent. Without support, mainstream classes may present situations where they cannot grasp concepts or complete assignments, serving only to diminish their self-image, increase their withdrawal, and increase the likelihood of depression. Not all students with AD, however, need placement in a special education classroom. With appropriate levels of support and modifications, many are successful in regular education settings.

Social/Emotional Support at Home and at School

- Teach the child appropriate steps to use when feeling stressed (e.g., deep breathing, counting to five, talking with an adult). Write the steps on a card which the child can carry at all times.
- Maintain a consistent schedule as much as possible. Prepare the child for changes in routine using picture cues, verbal cues and/or a posted daily agenda. Children with AD frequently become fearful, angry and upset when faced with unexpected changes.
- Teachers and parents should minimize affect in their voices. Be calm, predictable and matter-of-fact when dealing with the child with AD.
- Realize that the child with AD may not recognize that he/she feels sad or depressed. Just as children with AD do not perceive the feelings of others, they are often unaware of their own feelings.

Resources

The Institute for the Study of Developmental Disabilities is a nationally recognized resource of information relating to people with autism and other pervasive developmental disorder. Contact:

The Office of Information and Public Relations
Institute for the Study of Developmental Disabilities at Indiana University
2853 East Tenth Street
Bloomington, Indiana 47408-2601
(800) 437-7924

Books

Frith, U. (1991). *Autism and asperger syndrome.* New York, N.Y.: Cambridge University Press.

Klein, A. & Volkman, F.R. (1996). *Asperger syndrome: Treatment and intervention.* Learning Disabilities Association of America.

Siegel, B. (1996). *The World of the Autistic Child.* New York: Oxford University Press.

Internet

There are many informational sites pertaining to Asperger's Disorder on the Internet. One of the best websites is O.A.S.I.S., "Online Asperger Syndrome Information and Support." This provides immediate access to information as well as links to many other relevant websites.

<http://www.udel.bkirby/asperger/>

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Assistive Technology

A Handout for Teachers

by Lela Cunningham
BMP Tri-County Special Education Cooperative
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Western Illinois University

Definition of Assistive Technology

According to the Individuals with Disabilities Act (IDEA), an assistive device is "any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain or improve functional capabilities of children with disabilities." The provision of assistive technology devices and services may be special education, related services or supplementary aids and services to support a student with disabilities served in regular education (see 1997 Amendments to IDEA, Section 302).

Overview

Children with disabilities in schools present diverse problems for educators in the assessment of assistive technology needs, in the selection of specific interventions that are tailored to meet the individual needs and in writing IEP goals to reflect appropriate educational use of assistive or adaptive technology. Assistive devices in a classroom may range from low-cost, low-tech devices such as adaptive scissors or pencil grips to higher cost, high-tech items such as augmentative communication devices. Assistive technology devices are used both for students who need help participating in an educational program by remediating or correcting specific impairments such as hearing aides or communication devices, and to aid the student with specific learning deficits to perform specific tasks (e.g., using a spell checker).

According to a 1990 National Health Interview Survey on Assistive Devices sponsored by the National Center for Heath Statistics and National Institute for Disability and Rehabilitation Research, 13.1 million or 5.3% of the total U.S. populationin all age groups use assistive technology, but only 1% or about 1 million people under the age of 24 report using assistive technology devices. The devices listed in this survey include anatomical devices (braces/artificial limbs); mobility devices (crutches, wheel chairs); hearing/vision devices (white cane, hearing aides, TTY/TDD); speech/other devices (computer/typewriters); and accessibility features in homes (ramps, wider doors).

Looking at assistive technology needs and goals could be a daunting task unless some of the following issues and concerns are defined and discussed. Who can assess the assistive technology needs? What type of information is needed to make a decision about assistive technology needs? What are some of the practical and ethical concerns to look at when evaluating assistive technology needs? What are some guidelines for writing goals involving assistive technology?

Assessing Assistive Technology Needs

The need for assistive technology required for the student to receive a FAPE (free and appropriate education) must be determined on a case by case basis as a part of the case study evaluation, IEP and placement process. The assessment team members could be composed of all or some of the following personnel: school administrator, speech and language pathologist, psychologist, classroom teacher, classroom aide, occupational therapist, physical therapist, social worker, student, parents, the designated case manager and other people who may be significantly involved in the student's education and well being. Assistive technology evaluations must be consistent with the requirements included in IDEA and with Part 300 of the Code of Federal Regulations regarding referrals, qualifications of personnel, time lines for completion and due process. Each district may establish assistive technology guidelines that determine who is responsible for gathering data necessary for decision making and for insuring that the referral process is correctly completed.

A functional assessment — looking at practical, daily life skills to be used by the individual in his/her natural environment — is needed to help answer some of the following questions:

- What are the special needs, educational needs or communication needs of the student?
- What are the student's current abilities (cognitive, learning style, adaptive behavior strengths and weaknesses)?
- What materials and equipment are currently available that might meet those needs?
- What is the physical arrangement and instructional arrangement in the environment?
- What support is available in the school setting and in the home setting that will insure carry-over between the environments?
- What resources are available to the people supporting the student?
- How could activities be modified to accommodate the student's needs?
- What activities does the student need to participate in and how would technology support the student's participation in those activities?
- What options could be considered (no tech, low-tech or high-tech) to develop a system for the student with the defined specific needs?
- How can those options be explored in the student's normal environment (home and school)?
- What strategies can be used to increase the student's level of performance and interaction with the technology?

Considerations for preschool children: Assistive technology needs for children birth to three are addressed under Part H of IDEA (see Part C of the 1997 Amendments), and are considered in the "natural" environment of the child such as home, preschool or daycare. Assistive devices for this population are required only if related to developmental needs, such as mobility, interacting with the environment, communicating/interacting with others, and performing cognitive tasks involving cause and effect and making choices. The decision regarding the need for assistive technology for the birth to three population is made on an individual basis through the Individual Family Service Plan (IFSP) process.

Practical and Ethical Issues

- Is the assistive technology device that is being considered developmentally appropriate for the student? Augmentative communication systems should be used in a developmentally appropriate hierarchy from the use of concrete objects (direct selection of objects, pictures and line drawings) to abstract symbols (pictographic symbols and traditional letters) followed by an elementary communication device with recorded messages.
- If scanning for a response is involved, does the student have the ability to visually track and make a consistent choice? Children below a developmental age of 48 months may have difficulty attending to a lengthy scanning process, making it more appropriate to begin with systems that utilize the actual objects or miniature objects glued to a board.
- Is the device socially and personally appropriate for the student? Students will not use equipment for long if the use of the device makes the child feel ostracized or too different from their classmates. The equipment may be state of the art but if the student is not willing or comfortable interacting with the equipment, it won't be used consistently. You may want to try out equipment before purchasing.
- Has the student's learning style been identified and is the device appropriate for that style? The child may be an auditory learner and need to interact verbally but the device may function with only a visual output such as portable communication devices that produce a typed message.

- Does the student have the motor ability and muscle tone to operate the device consistently? This question can usually be answered best by the physical therapist or the occupational therapist.
- How much training time will be needed for the student to use the device and how much time will be necessary to train the staff and parents to assist the student to use the equipment?
- Who is going to accept the responsibility for on-going training of new personnel who deal with the student regarding the use of the assistive technology?
- Where will the student use the device? Although intended for school use, will the device also benefit the student in other environments such as the home setting?
- How is the device to be funded? In some cases, the family's insurance provider might support some or all costs. The physical therapist will be helpful in determining appropriate options.

Guidelines for Writing I. E. P. Goals

If the IEP team determines that assistive technology is required for the student to receive a FAPE, the IEP team must include specific statements in the IEP to designate the devices or services that the child needs. The IEP must reflect the nature and the amount of services and the extent that the child will be able to participate in regular educational programs. The student's education team can use the data gathered during the assessment of assistive technology needs to write an IEP that includes the recommendations for assistive technology services, devices or both as appropriate. The assistive technology services or devices may be included as a part of the student's present level of performance, annual goals or short-term objectives. The technology itself can be used as an educational goal area when the student is learning the function and operation of the assistive device.

As a part of a short-term objective, the assumption can be made that the student has achieved the ability to operate the equipment but is now learning to use it in a specific situation. It can also be used as a condition within a short-term objective (e.g., the use of a spell checker to reduce spelling errors). They may be listed as supplementary aids and services that need to be provided in order for the student to function in the least restrictive environment or in a list of related services necessary for the student to benefit from his or her educational programming.

Resources

Blackman, J. A. (1995). *Technology in early intervention.* Gaithersburg, MD: Aspen Publishers.

Church, G. & Glennen, S. (1992). *The handbook of assistive technology.* San Diego, CA: Singular Publishing Group, Inc.

National Rehabilitation Information Center: *<http://www.naric.com/naric>* or 800-346-2742. The NARIC is a library and information center on disability and rehabilitation funded by the National Institute on Disability and Rehabilitation Research. The web site includes information about the latest federally funded research grants, list of data bases (several states are listed individually with assistive technology resources), services available and indexes to specific topics.

Rehabilitation Engineering and Assistive Technology Society of America (RESNA) is an interdisciplinary association: 1700 N. Moore St., Ste. 1540, Arlington VA 22209; (703) 524-6686; *<http://www.resna.org/resna/reshome.htm>*

ABLEDATA is an electronic database of information on assistive technology and rehabilitation equipment: 8455 Colesville Rd., Ste. 935, Silver Spring, MD 20910; (800) 227-0216; *<http://www.abledata.com/index.htm>*

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Attention Deficit Disorder

A Primer for Parents

**by Elaine Morton Bohlmeyer, Ph.D, NCSP
with the school psychology staff of
Gilbert (AZ) Unified School District**

When a student is not doing well in school, especially if teachers also report that the student doesn't seem to concentrate in class and does not complete or turn in work, the parents may wonder if the child has an Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD). Sometimes such children are labeled "hyperactive," although it now is recognized that children can have attention deficits with or *without* overactive behaviors. It is important for parents to recognize the symptoms of ADD and to work with professionals in making an accurate diagnosis.

Characteristics of ADD

Students who have ADD may display a variety of characteristics, but some of the most common are impulsiveness, inattention, disorganization and distractibility. These children are often described as:

- not thinking before they act
- having difficulty following complex directions
- unable to wait
- having difficulty maintaining attention to tasks that are not basically interesting, such as school work or chores (but they may be able to watch TV or play computer games for hours!)
- unable to comply with a schedule
- frequently losing things

Parents often will say, "Even when I see him complete his homework, it never seems to get turned in." It is as if a "black hole" follows some of these children and swallows their homework and supplies. Some children get into fights often and are avoided or rejected by their peers. Others are very likeable and have many friends, although their friendships usually are not deep and lasting. They may get into trouble in school and in the community for doing things they know they shouldn't do, and they may be either extremely sorry or have a great many reasons why it wasn't their fault. The child may relate a feeling of being out of control or not being able to stop an activity. Parents may ask, "I know he knows better, and I know he's a good kid; why is he always in trouble?"

Diagnosing ADD

Many of the symptoms associated with ADD also may be symptoms of other childhood problems such as depression, anxiety or conduct disorders. Another problem with diagnosis is that there is no blood test or other specific medical test for ADD. Physicians and psychologists who diagnose ADD use observation, behavior reports from people who know the child well and a careful history. Sometimes there is a family history of ADD. In addition, the child's personal history is important because symptoms of true ADD will be present in a child before age seven and will be persistent over the years. If a child suddenly begins to exhibit these symptoms, especially if the child is older than seven, the behavior usually is a temporary response to something that is troubling him or her; however, it also may be the beginning of a deeper emotional problem.

Helping Children with ADD

Treatment of ADD is most successful when a variety of approaches are taken. First, it is important for parents to obtain as much information as possible about ADD. They can attend support groups in their school or community and there may be lectures and seminars provided by their school or mental health agencies. It helps for parents to meet together to learn that they are not alone with this problem and to discuss what other parents have found helpful. The school psychologist should be able to provide information about various resources and reading material.

Second, it usually is helpful for the child to have some individual or group counseling. Counseling may include information about ADD, social skills training and techniques that help the child remember to focus and think before acting. Older children may be taught strategies that will help them organize and complete tasks, such as using notebooks, checklists or timers.

Third, behavior techniques used by parents and teachers can help the child be more successful in meeting the demands of tasks. Since most ADD children really do want to behave well and to be able to finish assignments, they may respond to a prearranged nonverbal signal to return to their work. Positive reinforcement (praise, rewards) for following instructions and completing work may be helpful, but such reinforcement needs to be immediate and frequent. Children with ADD do not respond well to long-term rewards; opportunities to earn rewards need to be given every few minutes for preschoolers, several times a day for young elementary school children and at least daily for adolescents. Other specific techniques include:

- give the child only one or two steps of a direction at a time
- break a school assignment into several short assignments that an adult checks after each part is completed
- set a timer for a short period of time and challenge the child to see how much of a task can be completed before the timer goes off
- help the child to keep a daily calendar
- help the child to organize homework into a notebook

Using Medication for ADD

Finally, a physician might choose to prescribe medication. ADD is a neurobiological condition and medication helps the child to focus and benefit from instructional and behavioral support. Although some parents are reluctant to give their children medication, research shows that other treatments without the medication component rarely have lasting effects.

A great deal has been learned about ADD during the past five or ten years, so it is important to know what information is current and what is outdated. For example, professionals used to believe that children "outgrow" ADD at puberty and that medication and other treatments were not needed after that time. It now is known that, while most children do outgrow the excessive motor activity often associated with ADD, many people retain other symptoms throughout their adult lives and continue to respond favorably to counseling and medication. There is also evidence that some popular treatments, such as biofeedback, special diets and herbs, are ineffective. Until recently, it was thought that medications used for ADD might permanently stunt children's growth or worsen symptoms of Tourette's Syndrome (such as tics), but new information does not support these fears.

What if I Suspect My Child Has ADD?

If you suspect your child has ADD, you can expect the school to help you by providing behavior reports from teachers, either in written summaries or in the form of structured questionnaires or rating scales. If you have concerns about your child's academic progress or behavior, the school also should investigate whether or not symptoms of learning disabilities or emotional disorder are present. If your child is diagnosed as having ADD, the school is obligated to make reasonable accommodations for the child's condition, such as preferential seating or giving the child more time to complete assignments.

To pursue medical treatment, be sure to see a physician who is knowledgeable about ADD and medications. Work with your physician to find the right medication and the right dosage for your child. It used to be thought that dosage should be dependent upon body weight, but now it is known that each child responds differently to dosage level. During the time of adjustment, remember that most medications prescribed for ADD are short-acting and any undesirable (as well as favorable) effects wear off quickly. That is why many of these medications must be taken every few hours. If, however, your child also is being treated for other conditions, such as depression, the effects of medication for these other conditions may be longer-acting. Be sure to discuss side effects with your physician and report any concerns immediately!

Expect the school and physician to work together and communicate regarding the effectiveness of behavior techniques and response to medications. Both educational and medical professionals have unique contributions to make in the treatment process. While reports from school are crucial for monitoring the effects of medications, nobody in the school setting is qualified to prescribe them or change the dosage. While the physician may give helpful educational recommendations, it is not within the authority of a physician to prescribe specific tests or treatments within the school setting.

If your child is diagnosed as having ADD, remember that this condition likely can be fairly well controlled, but it also probably will be a life-long condition. Despite the best treatment, your child may never be as organized and methodical as typical peers. For example, do no expect your child to remember to take medication according to the prescribed schedule unless he or she clearly has demonstrated the ability to do so. Remember that, when your child needs the next dosage of medication, the effects of the last dosage are wearing off and that this is when the child tends to be least well-organized and responsible. Your child may always need more that the usual amount of help to organize tasks and materials, and he or she may never conform to rules and regulations as closely as you would like. However, if you emphasize the child's unique strengths and abilities, the disability may not seem so frustrating.

Resources for Parents

CHALLENGE Newsletter, Challenge, Inc., P.0. Box 488, W. Newbury, MA 011985; $25/yr. A national newsletter on Attention Deficit Disorder published six times a year.

Garber, S.W., Garber, M.D., & Spizman, R.F. (1993). *If Your Child is Hyperactive, Inattentive, Impulsive, Distractible...* New York: Villard Books.

Goldstein, S. & Goldstein, M. (1992). *Hyperactivity: Why Won't My Child Pay Attention?* New York: John Wiley & Sons, Inc.

Goldstein, S. & Goldstein, M. (1995). *A Parent's Guide: Attention-Deficit Hyperactivity Disorder in Children.* Salt Lake City, Utah: The Neurology, Learning & Behavior Center.

Ingersoll, B.D. & Goldstein, S. (1993). *Attention Deficit Disorder and Learning Disabilities: Realities, Myths and Controversial Treatments.* New York: Doubleday.

Maxey, D.W. (1993). *How to Own and Operate an Attention Deficit Kid.* Roanoke, VA: CHADD Support Groups.

Moss, R.A. with Dunlap, H.H. (1990). *Why Johnny Can't Concentrate.* New York: Bantam Books.

Silver, L.B. (1993). *Dr. Larry Silver's Advice to Parents on Attention-Deficit Hyperactivity Disorder.* Washington, DC: American Psychiatric Press, Inc.

Organizations

ADDAPPT: Attention Disorders Association of Parents and Professionals Together. P.O. Box 293, Oak Forest, IL 60452 (Publishes *ADDaptibility Newsletter*).

C.H.A.D.D. (Children and Adults with Attention Deficit Disorders). 499 NW 70th Ave. #109, Plantation, FL 33317. (305) 587-3700.

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ADHD: Resources for Parents and Educators

Books

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Barkley, R. A. (1997). *ADHD and the nature of self-control.* New York: Guilford.

DuPaul, G. J., & Stoner, G. (1994). *ADHD in the schools: Assessment and intervention strategies.* New York: Guilford.

Cordoni, B. (1987). *Living with a Learning Disability.* Carbondale, IL: Southern Illinois University Press.

Faber, A. & Mazlish E. (1980). *How to talk so kids will learn and listen so kids will talk.* New York: Rawson, Wade Publishers.

Fowler, M. (1992) *C.H.A.D.D. Educators Manual.* Plantation, FL: C.H.A.D.D.

Goldstein, S., & Goldstein, M. (1990). *Managing attention disorders in children: A guide for practitioners.* New York: Wiley.

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Kelly, K. & Ramundo, P. (1994). *You mean I'm not lazy, stupid, or crazy?! A self-help book for adults with Attention Deficit Disorders.* New York: Simon & Schuster (Audiotape version also available)

Kendall, P. (1988). *Stop and Think.* Merion Station, PA: Temple University Press.

Nadeau, K., (Ed.). (1995). *A comprehensive guide to Attention Deficit Disorders in adults.* New York: Brunner/Mazel

Nelsen, J. (1987). *Positive discipline.* New York: Ballantine Books.

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Silver, L. (1992). *The misunderstood child: A guide for parents of children with Learning Disabilities.* Bradenton, FL: Human Resources Institute

Solden, S. (1995). *Women with Attention Deficit Disorder: Embracing disorganization at home and in the workplace.*

Taylor, J. (1993). *The Attention Deficit/Hyperactive student at school: A survival guide for teachers and counselors.* Salem, OR: Sun Media.

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Taylor, J. (1993). *Anger control training for children and teens.* Wes ..inister, PA: Mar*Co Products.

Vernon, A. (1989). *Thinking, feeling, behaving.* Champaign, IL: Research Press.

Videotapes

Amen, Daniel. *Windows into The A.D.D. Mind.* The Center for Effective Living, 2220 Boynton Ave, Suite C, Fairfield, CA 94533 (800-793-9249).

Barkley, R. *ADHD — What Do We Know?* Guilford Press.

Barkley, R. *ADHD — What Can We Do?* Guilford Press.

Barkely, R. *ADHD in the Classroom: Strategies for Teachers.* Guilford Press.

Barkley, R. *ADHD in Adults.* Guilford Press.

Breggin, P. & Valentine, M. *The Myths of ADHD.* Children First, 23565 Via Paloma, Coto de Caza, CA 92679.

Taylor, J. *Answers to A.D.D.: The School Success Tool Kit.* Sun Media , 1095 25th St. SE, Suite 107, Salem, OR 97301; 1-800-847-1233 (available in both English and Spanish)

Organizations

ADDAPPT: Attention Disorders Association of Parents and Professionals Together. P.O. Box 293, Oak Forest, Il 60452 (Publishes ADDaptibility Newsletter)

CH.A.D.D. (Children and Adults with Attention Deficit Disorders). 499 NW 70th Av #109, Plantation FL 33317. (305) 587-3700.

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ADHD Children and Social Skills Training

A Handout for Teachers

by Patrick D. Sorensen
and Christina Commodore
University of Wisconsin-Milwaukee

Background

Attention Deficit/Hyperactivity Disorder (ADHD or ADD) is a biogenetically based disorder characterized by developmentally inappropriate difficulties with attention, impulsivity and (often) hyperactivity. Children with ADHD often demonstrate social skill problems and difficulties with interpersonal relations. Although school is the most important social experience outside the family, their frequently disruptive, noncompliant and restless behavior limit the positive opportunities for children with ADHD. Thus, the primary characteristics of the disorder interfere with the child's ability to develop appropriate social skills.

Impact of ADHD on Social Skills: Children with ADHD are often described as controlling, annoying and aversive by peers and tend to receive more negative social feedback from both peers and teachers. Due to their impulsivity and activity level, these children often seek to solve problems by physical means. ADHD children also may have difficulty accepting responsibility for their actions and attribute blame to others, often leading to further difficulties with peer relations. In some instances ADHD children may not have a *deficit* in social skills, but are unable to *produce* socially accepted behaviors in interpersonal situations , even though they "know" the appropriate behavior.

Because the ability to interact and share with others is a predominant contributor to a child's growth, children with social difficulties are significantly at-risk for later behavioral and emotional problems. As adults, individuals with ADHD often experience mental health problems, social isolation and employment difficulties.

Traditional Interventions for ADHD Children: Stimulant medications, including methylphenidate (Ritalin), pemoline (Cylert) or d-amphetamine (Dexedrine) are prescribed for 60%-90% of children with ADHD. In approximately 60-70% of ADHD children, medication has been shown to reduce aggressive, noncompliant and impulsive behavior and to improve attention. However, improvements in social behavior are most significant when medication is combined with behavioral management and/or social skills training. A combination of treatments has been shown to produce more positive long-term adjustment than medical or psychosocial intervention alone.

What can I do as a teacher? School is the most significant socializing agent for a child outside of the family. Teachers can be actively involved in developing positive social skills for ADHD children using training and self-monitoring strategies.

Social Skills training

Social skills training should occur in natural settings such as the school or home. Children are better able to maintain and generalize social skills when these are reinforced in the classroom, playground or in other social situations. Social skills training programs typically involve instruction, modeling, behavior rehearsal, coaching and feedback. Children are taught : *self expressive skills* (expressing feelings and opinion, accepting compliments, positive self-statements); *other-enhancing skills* (stating positives about others, stating genuine agreement or praise); *assertiveness* (making simple requests, disagreeing with others, denying unreasonable requests); and *communication skills* (conversing, interpersonal problem solving).

Instruction: The child is verbally taught to recognize social behaviors, such as participation, cooperation, communication, validation and support. Broad and specific skills are addressed. Examples of broad skills : "One should be positive to his/her friends because..." "Body posture and facial expressions communicate.." Specific skills might include: "Look the other person in the eye when beginning and maintaining a conversation..." "Take turns and share when involved in games."

Modeling: The child will enhance social skills while observing appropriate behaviors of others. For example, point out positive behavior of other students, point out your own behavior and use videotapes of appropriate behavior.

Behavior rehearsal: Provide the child with immediate social situations conducive to practicing the behaviors that have been taught. Effective strategies include role playing, small group opportunities (e.g., projects, cooperative learning), interactive games or playground activities, instructional activities that encourage student interaction and class discussions.

Coaching: Provide instructions to the child during behavior rehearsal. Important aspects of coaching include focusing on important concepts, teaching concepts and skills suggested by the child, providing specific behavioral examples in given situations, and asking the child to evaluate his/her social behaviors in terms of the outcome.

Feedback: Give the child immediate reinforcement for appropriate behaviors *during* rehearsal (e.g., "Great job..." "That time you didn't look away, you looked right at him..."). Feedback should also be provided to the child *following* rehearsal. The major aspects of the training program should be reemphasized:

- What skills did we focus on during the training?
- What appropriate behaviors did you observe in others?
- Review the activity (how did you feel?, how did others react?, what worked and what didn't?)
- Review the important steps and aspects of successful interaction or behavior
- Provide positive reinforcement and encourage the child to further develop skills

Self-monitoring Procedures in the Classroom

Step by step problem solving is an effective self-monitoring procedure that can be taught to the child. Problem solving steps can be posted in the classroom. Braswell and Bloomquist describe a 5-step problem-solving process which includes the following:

1. ***Identify the problem.***
   The child slows down and acknowledges the presence of a problem. Impulsive behavior is deterred and the child determines the source of the problem and the people affected ("What's the problem?").

2. ***Develop solutions.***
   The child generates alternative solutions to the problem ("What can I do?").

3. ***Select a solution.***
   The child chooses the best solution to the situation by considering the emotional and physical consequencesof the behavior on him/herself and others. Help the child anticipate possible problems with each solution("What will happen if I choose this behavior?").

4. ***Take action.***
   The child takes action using the selected solution ("What is my plan?").

5. ***Evaluate the solution and its consequences.***
   The child evaluates the effectiveness of the plan and its consequences. The child selects another alternativeif the first solution was ineffective ("How did I do?" "I did a great job!").

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ADHD Students in the Classroom

Strategies for Teachers

by Stephen E. Brock, Ph.D., NCSP
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Introduction

Affecting three to five percent of the population, Attention Deficit/Hyperactivity Disorder (ADHD) is one of the most common of the childhood behavior disorders. Associated with this disorder's core symptoms of inattention, hyperactivity and impulsivity are a variety of disruptive classroom behaviors (e.g., calling out, leaving seat, interrupting activities, etc.). Consequently, it is not surprising that these students are at risk for school failure.

Increased expectations for the use of classroom interventions for students with ADHD have been generated by Section 504 of the *Vocational and Rehabilitation Act of 1973* and the *Individuals with Disabilities Education Act* (IDEA) of 1997. Section 504 has been used to require the development of general education accommodation plans. These plans are designed to ensure that the student with ADHD is provided a free and appropriate education. Among the recommended components of these plans are a variety of classroom interventions (including behavior management), with a special emphasis on environmental modifications. Similarly, the recent reauthorization of *IDEA*, with its requirements for functional assessments, should increase the frequency with which classroom-based behavioral interventions are considered for these students.

General Behavior Intervention Suggestions

Classroom interventions for the student with ADHD should be based upon a solid foundation of general behavior intervention principles. While students with ADHD do have a core of common problems, this group is fairly heterogeneous. Thus, instead of focusing on ADHD symptoms, management should first directly target the specific problem behavior. Next, an alternative behavior, incompatible with the problem behavior, should be selected. It is important to keep both behaviors in mind. Not only do we want to make it clear to students what behavior is unacceptable (what we don't want them to do), but we also want to make it clear what behavior is acceptable (what we want them to do). These behaviors should be carefully defined so that the teacher will be able to accurately monitor them.

It is also important to ensure that the behavior intervention plan is based upon a careful functional assessment of behavior. Antecedents and consequences of both the problem and replacement behaviors need to be studied. Antecedents will suggest environmental changes that set up the student for success or failure. Analysis of consequences, on the other hand, will identify those environmental contingencies that serve to reinforce both desired and undesired behavior. The function of the problem behavior should guide intervention plans. For example, if the behavior is maintained by negative reinforcement (e.g., avoidance of an undesired task), then the intervention should ensure that this goal is not obtained by the problem behavior. At the same time the intervention should teach the student that the desirable behavior is a more effective way of obtaining the behavioral goal.

Environmental and Instructional Considerations

Task Duration

To accommodate to the student's short attention span, academic assignments should be brief and feedback regarding accuracy immediate. Longer projects should be broken up into manageable parts. Short time limits for task completion should be specified and can be enforced with timers.

Direct Instruction

Attention to task is improved when the student with ADHD is engaged in teacher-directed as opposed to independent seat-work activities. Also, the teaching of note-taking strategies increases the benefits of direct instruction. Both comprehension and on-task behavior improve with the development of these skills.

Peer Tutoring

Class-wide peer tutoring provides many of the instructional variables known to be important in setting up students with ADHD for success. For example, it provides frequent and immediate feedback. When combined with a token economy, peer tutoring has been found to yield dramatic academic gains.

Scheduling

Based on evidence that the on-task behavior of students with ADHD progressively worsens over the course of the day, it is suggested that academic instruction be provided in the morning. During the afternoon, when problem solving skills are especially poor, more active, nonacademic activities should be scheduled.

Novelty

Presentation of novel, interesting, highly motivating material will improve attention. For example, increasing the novelty and interest level of tasks through use of increased stimulation (e.g., color, shape, texture) reduces activity level, enhances attention and improves overall performance.

Structure and Organization

Lessons should be carefully structured and important points clearly identified. For example, providing a lecture outline is a helpful note-taking aid that increases memory of main ideas. Students with ADHD perform better on memory tasks when material is meaningfully structured for them.

Rule Reminders and Visual Cues

The rules given to students with ADHD must be well defined, specific and frequently reinforced through visible modes of presentation. Well-defined rules with clear consequences are essential. Relying on the student's memory of rules is not sufficient. Visual rule reminders or cues should be placed throughout the classroom. It is also helpful if rules are reviewed before activity transitions and following school breaks. For example, token economy systems are especially effective when the rules for these programs are reviewed daily.

Auditory Cues

Providing students with ADHD auditory cues that prompt appropriate classroom behavior is helpful. For example, use of a tape with tones placed at irregular intervals to remind students to monitor their on-task behavior has been found to improve arithmetic productivity.

Pacing of Work

When possible, it is helpful to allow students with ADHD to set their own pace for task completion. The intensity of problematic ADHD behaviors is less when work is self paced, as compared to situations where work is paced by others.

Instructions

Because students with ADHD have difficulty following multi-step directions, it is important for instruction to be short, specific and direct. Further, to ensure understanding, it is helpful if these students are asked to rephrase directions in their own words. Additionally, teachers must be prepared to repeat directions frequently, and recognize that students often may not have paid attention to what was said.

Productive Physical Movement

The student with ADHD may have difficulty sitting still. Thus, productive physical movement should be planned. It is appropriate to allow the student with ADHD opportunities for controlled movement and to develop a repertoire of physical activities for the entire class such as stretch breaks. Other examples might include a trip to the office, a chance to sharpen a pencil, taking a note to another teacher, watering the plants, feeding classroom pets, or simply standing at a desk while completing classwork. Alternating seat work activities with other activities that allow for movement is essential. It is also important to keep in mind that on some days it will be more difficult for the student to sit still than on others. Thus, teachers need to be flexible and modify instructional demands accordingly.

Active vs. Passive Involvement

In line with the idea of providing for productive physical movement, tasks that require active (as opposed to passive) responses may help hyperactive students channel their disruptive behaviors into constructive responses. While it may be problematic for these children to sit and listen to a long lecture, teachers might find that students with ADHD can be successful participants in the same lecture when asked to help (e.g., help with audio-visual aids, write important points on the chalk board, etc.).

Distractions

Generally, research has not supported the effectiveness of complete elimination of all irrelevant stimuli from the student's environment. However, as these students have difficulty paying attention to begin with, it is important that attractive alternatives to the task at hand be minimized. For example, activity centers, mobiles, aquariums and terrariums should not be placed within the student's visual field.

Anticipation

Knowledge of ADHD and its primary symptoms is helpful in anticipating difficult situations. It is important to keep in mind that some situations will be more difficult for than others. For example, effortful problem solving tasks are especially problematic. These situations should be anticipated and appropriate accommodations made. When presenting a task that the teacher suspects might exceed the student's attentional capacity, it is appropriate to reduce assignment length and emphasize quality as opposed to quantity.

Contingency Management: Encouraging Appropriate Behavior

Although classroom environment changes can be helpful in reducing problematic behaviors and learning difficulties, by themselves they are typically not sufficient. Thus, contingencies need to be available that reinforce appropriate or desired behaviors, and discourage inappropriate or undesired behaviors.

Powerful External Reinforcement

First, it is important to keep in mind that the contingencies or consequences used with these students must be delivered more immediately and frequently than is typically the case. Additionally, the consequences used need to be more powerful and of a higher magnitude than is required for students without ADHD. Students with ADHD need external criteria for success and need a pay-off for increased performance. Relying on intangible rewards is not enough.

Use of *both* negative and positive consequences are essential when working with ADHD students. However, before negative consequences can be implemented, appropriate and rich incentives should first be developed to reinforce desired behavior. It is important to give much encouragement, praise and affection as these students are easily discouraged. When negative consequences are administered, they should be given in a fashion that does not embarrass or put down students. Also, it is important to keep in mind that the rewards used with these students lose their reinforcing power quickly and must be changed or rotated frequently.

Token Economy Systems

These systems are an example of a behavioral strategy proven to be helpful in improving both the academic and behavioral functioning of students with ADHD. These systems typically involved giving students tokens (e.g., poker chips) when they display appropriate behavior. These tokens are in turn exchanged for tangible rewards or privileges at specified times.

Response-cost Programs

While verbal reprimands are sufficient for some students, more powerful negative consequences, such as response-cost programs, are needed for others. These programs provide mild punishment when problem behavior is displayed. For example, a student may lose earned points or privileges when previously specified rules are broken. There is evidence that such programming decreases ADHD symptoms such as impulsivity. A specific response-cost program found to be effective with ADHD students involves giving a specific number of points at the start of each day. When a rule is broken (a problem behavior is displayed), points are taken away. Thus, to maintain their points students must avoid breaking the rule. At the end of the period or day, students are typically allowed to exchange the points they have earned for a tangible reward or privilege.

Time-out

Removing the student from positive reinforcement, or time-out, typically involves removing the student from classroom activities. Time-out can be effective in reducing aggressive and disruptive actions in the classroom, especially when these behaviors are strengthened by peer attention. They are not helpful, however, when problem behavior is a result of the students desire to avoid school work. The time-out area should be a pleasant environment and a student should be placed in it for only a short time. Time-out is ended based upon the student's attitude. At its conclusion a discussion of what went wrong and how to prevent the problem in the future takes place. While these procedures are effective with ADHD students, it is recommend that they be used only with the most disruptive classroom behaviors and only when there is a trained staff.

Summary

As students with ADHD are a heterogeneous group, there is no one intervention (or set of interventions) that will improve the classroom functioning of all of these students. Thus, it is suggested that classroom modifications be tailored to the unique needs of each student. In developing these modifications it is perhaps best to begin by examining how the classroom environment might be changed to set up the student with ADHD for success. The next step is to consider the implementation of a contingency management system designed to provide external incentives for appropriate classroom behaviors. In doing so it is important to remember that behavior management programs must be consistently applied. Further, it is essential to avoid excessive use of negative consequences (such as reprimands, time-out). In all cost programs, it is important to avoid the use of unrealistic standards that result in excessive point or privilege loss. Students must experience success. In other words, it is essential that students be frequently reinforced for what we want them to do, rather than simply punished for what we do not want them to do.

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ADHD Look-Alikes

Guidelines for Parents

by Servio Carroll, NCSP
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Background

There are many psychological and medical problems that look like ADHD, so children who present the typical signs of Attention Deficit Hyperactivity Disorder need to be carefully evaluated. Look-alike ADHD children may meet the diagnostic criteria for ADHD but have a completely different problem. It is important to distinguish between the conditions because their long-term course and treatment may be quite different from children with classical ADHD.

Depression

Depression is as common in children as it is in adults. While it may seem unlikely that a depressed person would be "hyper" (since many depressed people seem to talk and think slowly and move with real effort), some inattentive children with impulsive and hyperactive behavior are actually depressed. These children may have mild symptoms and just feel blue or demoralized, or have more persistent symptoms like chronic bad moods (dysthymic disorder), or have the psychiatric diagnosis of depression with its accompanying physical changes (major depression). Even though these children may show ADHD-like symptoms, treating the depression will help more than treating the ADHD symptoms.

Stress-induced Anxiety States

Anxiety caused by a stressful environment may present as ADHD. Children living in a stressful home situation or who are dealing with social or family problems or academic pressures may look like they have ADHD. Obviously, helping them cope with the stress in their lives is the answer, rather than using stimulant medications, which may increase their anxiety. Even mild stress can produce symptoms like ADHD.

Biologically-based Anxiety Disorders

Even though many of the symptoms of certain medical conditions, such as separation anxiety or obsessive compulsive disorder, may look like ADHD, they are treated quite differently. Again, stimulants given to treat ADHD often worsen the symptoms of these anxiety disorders, which are better treated with anti-anxiety and mood stabilizing medications and other approaches.

Child Abuse or Neglect

In certain cases, the victims of sexual abuse, physical abuse or neglect display the symptoms of ADHD. Even after a limited period of abuse or neglect, these children may continue to show symptoms that are difficult to distinguish from ADHD.

Bipolar Disorder

Bipolar disorders are being more frequently identified in children. This family of disorders has symptoms that may look like ADHD. The most severe form of bipolar disorders in adults is manic-depressive illness, but most common bipolar disorders are milder. Likewise, only children with the more severe forms of bipolar disorder show amazingly energized and lengthy temper tantrums with gross destructiveness during their brief or lengthy rages. In children, the milder forms of bipolar disorders present as impulsivity, inattention, hyperactivity and also with overly strong emotions, feelings, an overbearing manner, irritability or unprovoked hostility, and often difficulty in "getting going" in the morning.

While about half of boys and perhaps a quarter of the girls with bipolar disorders also meet the diagnostic criteria for ADHD, bipolar disorders tend to appear in families with a history of depression or bipolar disorders. Although stimulants can sometimes help these children with bipolar disorders, stimulants often make the symptoms worse and can be quite risky. Mood stabilizing medications can be much more helpful.

Schizophrenia

Schizophrenia is a serious illness that can include ADHD symptoms. Schizophrenia is uncommon in children, but when seen, there is usually a family history for the disease. Again, stimulant medications can be risky for these children.

Other Medical Disorders

Certain medical disorders such as sleep or arousal problems, malfunctions of the thyroid gland and lead poisoning may also give ADHD like symptoms.

Summary: Cautions in Diagnosis and Treatment

Given the variety of disorders that can be mistaken for ADHD, or that may be present with ADHD, a comprehensive evaluation of the child is always important. Numerous problems must be considered, assessed and "ruled out" before a diagnosis of ADHD can be made. It is no longer sufficient to start treatment for ADHD based on observations of "tuning out" or misbehavior. ADHD needs a psychological and medical evaluation that matches our growing awareness of the complexity that goes by the simple name of ADHD.

If a medical or psychiatric disorder is presenting as ADHD, and the child's condition is worsening with age, it is important to consider the possibility that ADHD may not be the only, or even *the* problem. Also, if the child has bad dreams, bad moods or disturbing thoughts, or if there is a family history of psychiatric disorders, then it is important to be sure that Look-Alike disorders and additional problems are not present. If another condition is present, a treatment that only improves the ADHD symptoms will leave behavioral problems, mood abnormalities or chemical imbalances untreated. In these cases, even if stimulants are helpful or if environmental changes improve the child's self control, it is critical to make sure that the other, and perhaps more serious, problems are not left untreated.

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Guidelines for Educators

by Servio Carroll, NCSP
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Background

Due to the wide variety of psychomedical and biomedical problems that can be mistaken for Attention Deficit Hyperactivity Disorder (ADHD), or that may co-exist with ADHD, it is always essential for a child to be carefully evaluated. Medical specialists are working to develop a more precise idea of which hyperactive children and adolescents really have ADHD and which have look-alike problems that only resemble this disorder. Look-alike ADHD children may fulfill the diagnostic criteria for ADHD but have a completely different problem and, therefore, should receive a different diagnosis. These ADHD look-alikes are important to distinguish because their long-term course and treatment may be quite different from children with classical ADHD. There are several psychomedical problems or medical disorders that can mimic ADHD, resulting in an ADHD look-alike child.

Depression

Depression is certainly common in adolescents and children, just as it is in adults. While it may seem unlikely that a depressed person would be "hyper" (since many depressed people seem to talk and think slowly, and move with real effort), some inattentive children with impulsive and hyperactive behavior are actually depressed. These children may just have passing symptoms of depressed mood (e.g., feeling blue or demoralized) or more persistent or even chronically bad moods (dysthymic disorder), or have the psychiatric diagnosis of depression with its accompanying physical changes (major depression). Even though these children may have prominent ADHD-like symptoms, treating their depression is more successful than treating the ADHD symptoms.

Stress-induced Anxiety States

Anxiety states caused by environmental stress may present as ADHD. Certain children living in a stressful home situation or adolescents dealing with social or academic pressures may look like they have ADHD. Obviously, helping them cope with the stress in their lives is preferable to the use of stimulant medications. Even mild stress can produce symptoms that mimic ADHD.

Biologically-based Anxiety Disorders

Certain medical disorders such as separation anxiety disorder or obsessive compulsive disorder are treated quite differently from ADHD — even though many of the symptoms of these disorders may look the same as ADHD symptoms. However, stimulants often worsen the symptoms of these anxiety disorders, which are better treated with different medications and approaches.

Child Abuse or Neglect

In certain circumstances, the victims of sexual abuse, physical abuse or neglect can present with symptoms of ADHD. Even after a limited period of abuse or neglect, these children may continue to show symptoms that are difficult to distinguish from ADHD.

Bipolar Disorders

Another biomedical condition that may mimic ADHD is the family of bipolar disorders. The most severe version of bipolar disorder in adults is manic-depressive illness, but most common bipolar disorders are more mild. Bipolar disorders in children and adolescents can present with impulsivity, inattention and hyperactivity, along with overly strong feelings or an overbearing manner, irritability or unprovoked hostility, and often difficulty in "getting going" in the morning. It is only the more severe forms of bipolar disorder in adolescents and children that show amazingly energized and lengthy temper tantrums with gross destructiveness during their brief or lengthy rages. About half of boys (and perhaps a quarter of the girls) with bipolar disorders fulfill diagnostic criteria for ADHD, but bipolar disorder tends to appear in families in which depression or bipolar disorder has emerged before. Although stimulants can sometimes help these children with bipolar disorder, stimulants often make the symptoms worse and can be quite risky. Lithium and other medications can be much more helpful.

Schizophrenia

Schizophrenia is a serious biomedical disorder that can include ADHD symptoms. Children with schizophrenia are relatively uncommon, typically come from families in which schizophrenia has emerged before, and represent an extremely small fraction of the children with ADHD symptoms. Again, stimulant medications can be risky for these children, and other medications and treatments are strongly preferable.

Other Medical Disorders

Certain medical disorders of sleep (or arousal), malfunctions of thyroid gland and excessive lead ingestion may also present with symptoms that are typically seen in children with ADHD.

Summary: Cautions in Diagnosis and Treatment

Look-alike ADHD children may meet the diagnostic criteria for ADHD, but have a completely different problem and, therefore, should receive a different diagnosis and different course of treatment. All of the above conditions may cause a child to behave impulsively and show difficulties in attention and hyperactivity that are hard (and perhaps impossible in some instances) to distinguish from ADHD. Particularly if a child's situation is worsening with age, it is important to consider the possibility that ADHD may not be the sole or even primary problem. Also, if the ADHD is associated with bad dreams, bad moods or disturbing thoughts, or if there is a family medical history of psychiatric disorders, then it is important to be sure that mimicking disorders and ADHDitional problems are not present.

If a medical or other psychiatric disorder is presenting as ADHD, a treatment that merely improves the ADHD symptoms may leave a residue of untreated behavioral problems, mood abnormalities or disorders of physiology. In these cases, even if stimulants are helpful or if environmental changes improve the child's self control, it is critical to make sure that the other (and perhaps more serious) problems are not left to smolder.

Given the variety of disorders that can be mistaken for ADHD, or that may co-exist with ADHD, a comprehensive evaluation of the child is always important. Numerous problems must be contemplated, assessed and "ruled out" before a diagnosis of ADHD can be made. It is no longer sufficient to start treatment for ADHD based on observations of "tuning out" or misbehavior. This disorder needs a psychomedical evaluation that matches our growing awareness of the complexity that goes by the simple name of ADHD.

Resources

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Attention Disorders: Interventions for Adolescents

by Peg Dawson and Richard Guare
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AREAS OF DIFFICULTY	POSSIBLE INTERVENTIONS
Organization	
Doesn't do homework	Homework Survival Guide (*Communiqué*, June 1994) Incentive system Supervised study hall Alternative homework assignments Self-designed homework After school homework sessions in school
Loses homework/possessions	Daily check-ins (home/school) — monitoring system Organizational aids (checklists/reminders/routines) Targeted incentive system
Doesn't come to class prepared	Case manager or other monitoring system Spare materials in classes students can borrow/rent Targeted incentive system
Disorganized notebooks	Monitoring system (e.g., daily notebook check) Don't penalize (e.g., grading modifications)
Messy work	Computer access Specify clear criteria — have student redo if work doesn't meet criteria Incentive system Modify expectations
Planning	
Prioritizing	Students with attention disorders need assistance in these areas and cannot be expected to perform these skills without adequate instruction and practice. This could occur in planning periods built into the student's day. Instruction may follow a sequence such as: 1) define skill to be learned; 2) model skill; 3) have student engage in verbal rehearsal; 4) guided practice; 5) independent practice with follow-up. A second option is the use of a coach (described in Hallowell & Ratey, *Driven to Distraction*).
Breaking tasks down	
Setting goals	
Planning steps	
Time management	

AREAS OF DIFFICULTY	POSSIBLE INTERVENTIONS
Remembering	
Handing in assignments	Case manager to monitor Home/school daily check-in Incentive system
Knowing when things are due	Case manager to monitor Home/school daily check-in Incentive system
Bringing materials to/from school	Case manager to monitor Home/school daily check-in Incentive system
Math facts/other rote memory tasks	Memory aids Allow use of calculators Reduce demands/expectations
Sequence of steps to follow (e.g. math)	Construct personalized instructional manual with templates, directions, examples of problems, models, etc.
Following Directions	
Verbal	Provide study partner Repeat directions individually
Written	Check-in with student/clarify as necessary Highlight directions for student/have student highlight
Written Production	
Poor fine motor skills/ motor impersistence	Allow to dictate written responses Allow the use of tape recorders Access to computers for writing assignments Reduce writing requirements
Discrepancy between thinking/ writing speed	Access to computers/recorders Opportunity to respond orally
Difficulty organizing thoughts	Assistance with prewriting activities (e.g., brainstorming, mind mapping, outlining) Writing ideas on post-its, rearranging to outline
Problems with initiation/word retrieval	Brainstorming vocabulary, key concepts Helping getting started Close-ended writing tasks
Proofreading problems	Use spellcheck Have another student/adult proofread Use proofreading checklist to cue for specific errors

AREAS OF DIFFICULTY	POSSIBLE INTERVENTIONS
Problems with Test-Taking	
Careless mistakes	Allow test re-takes Supervise checking work
Can't finish within time limits	Allow extra time Break testing into several sessions
Writing problems	Oral exams Short answer/multiple choice vs. essay Reduce demands/allow extra time
Distracted during testing	Let student take test in quiet room
Anxiety	Teach test-taking strategies Teach relaxation strategies Let student take test away from other students
Difficulties with retrieval	Multiple choice tests Open book tests Provide sample items/templates Cues to aid retrieval during test Teach test-taking strategies
Social Skills	
Impulsive	Consider the following for all social skills problems: Incentive systems
Disruptive	Negotiated behavior contract Match student with teacher
Apathetic	High rate of personalized positive feedback Alternative curriculum
Discouraged	Credit for out-of-school learning Work-study programs
Depressed	Hands-on learning
Cognitive Style	
Fast and sloppy	Assign shorter tasks with criterion for accuracy Teach self-evaluation/goal-setting re accuracy or quantity
Problems with initiation	Assign close-ended tasks Provide templates Help student get started (e.g., walk through 1st few items/brainstorm ideas, etc.) Assign study partner Use cooperative learning Assign shorter task/break tasks down

AREAS OF DIFFICULTY	POSSIBLE INTERVENTIONS
Cognitive Style (continued)	Obtain verbal commitments (e.g., re start times)
Low frustration tolerance	Modify assignments Ensure high rate of success Frequent reinforcement Provide individual help Self-designed assignments (brainstorm ideas)
Processing speed/simultaneous processing problems (e.g., can't listen and take notes)	Provide individual help Tape lectures Provide note-takers or access to teacher notes Present material in organized, sequential fashion Reduce assignments/allow extra time
Craves novelty/hates repetition	Avoid lecture style classes Avoid classes with heavy rote learning or worksheet requirements Computers/technology Use cooperative learning Use hands on learning/discussion format Self-designed assignments Individualized work contracts Assign to high energy teachers Avoid needless repetition Build in breaks/opportunities to move around Vary formats within/across class periods

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Attention Problems

Strategies for Parents

by Marcia Weill
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Hyperactivity: Provide External Structure

Physical Controls

- Include regular exercise, balanced diet, adequate sleep, medication if appropriate
- Check schedules: mornings usually best for learning, need calm routine at bedtime
- Check environment for safety and remove treasured items, prevent problems

Predictability

- Use consistent rules across time and place
- Prepare for changes to new activity
- Practice simple daily routines
- Have regular contact with school

Distractibility: Focus on Priorities

Priorities

- Organize backpack and notebook
- Have a "Launch Pad" area for next morning's materials and messages
- Encourage on-task behavior
- Request special education assessment if appropriate

Directions

- Use simple, positive directions showing what to do instead of what not to do
- Give visual clues

Distractors

- Provide regular time and clean area for doing homework
- Limit and balance extra curricular activities

Impulsivity: Build Self-Confidence

Social Skills

- Build on strengths
- Teach game-playing skills, taking turns and making choices
- Encourage noncompetitive sports (karate, gymnastics, swimming)
- Teach friendship skills (making requests, giving compliments, less rough play)

Parent Support

- Enroll in classes in behavior management
- Join support groups
- Use "special time" for bonding

Counseling and Management

- Use strategies to reduce impulsive behavior
- Model positive self-talk and goal-setting
- Reward frequently

Adapted from material previously published by the California Association of School Psychologists in CASP Today, *August, 1994.*

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Attention Problems

Strategies for Teachers

by Marcia Weill
Folsum-Cordova (CA)Unified School District

Hyperactivity: Provide External Structure

Physical Controls Predictability

- Give energy breaks, opportunities for focused movement
- Minimize changes and pullouts
- Provide individual desks & space for extra materials
- Prepare for transitions
- Include short, fast-paced tasks; practice routines
- Be calm (soothing music, carpet, earplugs)
- Develop physical cues to refocus

Distractibility: Focus on Priorities

Priorities

- Use anticipatory set with frequent restatement of purpose
- Provide only needed materials
- Modify tasks: shorten, highlight, use markers and windows for tracking, break into manageable steps
- Teach summarizing skills
- One idea per paragraph or page

Directions

- Start with one step, student restates in own words beforeperforming independently
- Vary voice pitch and pacing of lesson
- Teach memory strategies (mnemonics, note taking, brain storming)
- Insist on instructional readiness (body still, eye contact)

Distractors

- Use multi-sensory materials and "hands on" learning to engage
- Locate student away from visual and auditory distractors (heating/air conditioning, traffic and stimulating bulletin boards)
- Seat student by organized, understanding peers

Impulsivity: Build Self Confidence

Social Skills

- Give opportunities for leadership, being a tutor for younger students, reinforce each step to success
- Use cooperative learning groups, giving a responsibility he or she can do
- Provide practice making choices, impulse control, empathy

Parent Support

- Send frequent progress reports
- Give honest feedback, mostly positive

Counseling

- Reinforce time-on-task (process), fading to task completion (product)
- Encourage risk-taking and positive self-talk
- Build on strengths, teach compensating skills and remind of successful accomplishments
- Use contracts with frequent reinforcement for desired behaviors and response-cost for negative behaviors

Adapted from material previously published by the California Association of School Psychologists in CASP Today, *August 1994.*

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Autism

A Handout for Teachers

**by Elizabeth Rudrud, Ed.S.
Minneapolis Public Schools**

Definition

Autism is a life-long, low incidence developmental disability which occurs in the first three years of life. It is a behaviorally defined syndrome characterized by an uneven developmental profile and disturbances in: 1) social interaction; 2) communication; and 3) perceptual organization. Autism is one of several disorders defined by the spectrum of behaviors that makes up the category of Pervasive Developmental Disorders. Autism occurs by itself or in association with other disorders such as mental retardation.

Facts

- Autism is a physical disorder of the brain that affects developmental rate, the modulation of perception, language, cognitive and intellectual development, and the ability to relate to others.
- 10-15 out of 20,000 people of all races, cultures and educational backgrounds are identified as having autism. This is a low incidence disorder.
- Autism is about four times more common in boys than in girls.
- At present no specific cause or causes have been identified. Some children develop autism in conjunction with other diseases which affect the central nervous system such as maternal rubella, phenylketonuria, encephalitis, meningitis and tuberous sclerosis.
- There is no medical treatment that will cure autism. Some medications may help minimize some of the symptoms. Early intervention and education are the most effective methods of treatment.

Behavioral Symptoms

Children with autism exhibit difficulty interacting with peers and/or adults in their environment. Their social skills may resemble the following spectrum of behaviors:

- A lack of awareness of the existence or feelings of others which may be demonstrated by an avoidance of eye contact, no social smiling or greeting, little or no joint attention with others, inability to empathize, limited awareness of social boundaries and privacy issues, inappropriate laughing, social anxiety or avoidance.
- Little or unusual seeking of comfort at times of distress.
- Little or no imitation play which may be demonstrated by minimal participation in action songs/finger plays, limited curiosity, limited modeling of peers when not sure of what to do.
- Little or no social play which may be demonstrated by exclusive solitary play, difficulty establishing joint attention in activities, self-isolation, difficulties initiating and maintaining play, inappropriately intrusive, difficultly learning and following rules as well as winning, loosing and negotiating during games, and difficulty shifting attention from one thing to another.
- Great difficulty in making and keeping peer friendships.

Children with autism exhibit difficulty relating their thoughts, feelings and overall wants and needs. Their language development may resemble the following spectrum of behaviors:

- No mode of communication — only idiosyncratic signals and the use of other's body to communicate.
- Unusual nonverbal communication which may be demonstrated by no conventional gestures such as nodding or waving, no use of pointing to express interest, flat affect.
- Absence of imaginative activity which may be demonstrated by limited understanding of jokes, sarcasm, idioms and multiple meanings, concrete and literal thinking, and inability to take another's perspective.
- Unusual qualities in the production of speech such as talking too fast or slow, speaking in monotone or sing-song voice, and inappropriate volume for situations.
- Unusual form or content of speech which may include echolalia, inappropriate questioning, idiosyncratic language, verbal rituals, and difficulty understanding and answering questions and following directions.
- Difficulty in the ability to initiate or sustain a conversation with others, despite adequate speech.

Children with autism demonstrate a restricted range of activities and interests. Their activities may resemble the following spectrum of behaviors:

- Unusual body movements such as pacing, jumping twirling, staring, repetitive hand movements and posturing.
- Persistent preoccupation with parts of objects which may include spinning and twirling objects, lining up objects, or a fascination with watching moving objects.
- Strong distress over change in small aspects of the environment, for example, the position of furniture.
- Unreasonable insistence on following routines in precise detail; this includes anxiety with transitions.
- A restricted range of interests and a preoccupation with one narrow interest, for example, an intense interest in certain videos or an intense interest in trains or dinosaurs.

Intervention Strategies

- Involve the child in turn-taking activities that require shared space and materials. Provide structure and support to help the child remain engaged and wait his/her turn. Use familiar short songs or counting activities in a predicable way.
- Encourage the child to join a peer who is using a favored toy. Model and parallel talk appropriate ways for the child to join his/her peer (e.g., " First peer's turn, then child's turn").
- Use pictures and visual charts so that the child does not have to rely on language which is not always working for them, especially during transitions. In school or at home, it is helpful to use picture systems to represent daily activities such as snack, music, gym, etc.
- Pictures can also be used to help communicate wants and needs. Pictures of favorite activities can be used to help the child learn to make more choices and to help give them a sense of control.
- Break down directions into short, simple statements. The use of predictable and consistent language is also a key to helping the child process and respond to the direction or tasks at hand.
- Reduce the level of distraction and stimulation so that the child can attend to language. The child's ability to process language may be variable depending on the level of environmental stimulation, activity level, novelty of the situation or emotional factors such as anxiety, frustration or fear. Increased structure and visual cues may be necessary to help the child focus attention.

- When possible, look at the communicative intent of the child's behavior and provide them with the words that describe what they are attempting to communicate.
- Teach social skills and social interactions specifically in a structured way. This enables a child to prepare for situations and interactions which are most likely fear- and anxiety-producing.
- Be aware of sensory stimulation in the environment, and help the child plan ahead and anticipate sensory input. In addition, use sensory input to help the child de-escalate behavior or focus attention.
- Because students with autism often have a difficult time transferring a skills they have learned in one setting and applying it to another setting, it is important to teach skills in as many environments with as many people as possible.

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Deaf and Hard of Hearing

Resources for Educators, Parents and Students

by William P. Kachman, Ph.D., NCSP
and Steven T. Hardy-Braz, Psy.S., NCSP
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National Organizations for the Deaf and Hard of Hearing

Alexander Graham Bell Association for the Deaf, 3417 Volta Place, NW, Washington, DC 20007; (202) 337-5220 v/t

American Society for Deaf Children, 2848 Arden Way, Suite 210, Sacremento CA 93825-1373; (800) 942-asdc v/t

American Speech Language Hearing Association, 10801 Rockville Pike, Rockville MD 20852; (800) 638-8255 v/t

National Association of the Deaf, 814 Thayer Ave, Silver Spring MD 20910; (301)587-1788 v, (301) 587-1789 t; (301)587-1791 fax

National Information Center on Deafness, Gallaudet University, 800 Florida Ave NE, Washington DC 20002-3695; (202) 651-5051 v; (202) 651-5052 t

National Institute on Deafness and other Communication Disorders Clearinghouse, 1 Communication Ave, Bethesda MD 20892-3456; (800) 241-4044 v; (800) 241-1055 t ; (301) 907-8830 (fax)

Outreach Department, Pre-College National Mission Programs , Gallaudet University, 800 Florida Ave. NE, Washington DC 20002-3695; (202) 651-5340 v/t

Other Organizations

American Deafness And Rehabilitation Association, PO Box 251554, Little Rock AR 72225; (501) 858-8850 v/t; (501) 868-8812 fax

Association for Late Deafened Adults, 10310 Main St. Box 274, Fairfax VA 22030; (815) 899-3040 v/t; (815) 899-4517 fax

House Ear Institute, 2100 West Third Street, 5th floor , Los Angeles CA 90057; (213) 483-4431v; (213) 484-2642 t; (213) 483-8789 fax

John Tracy Clinic, 806 West Adams Blvd., Los Angeles CA 90007; (800) 522-4582 v/t; (213) 749-1651 fax

National Cued Speech Association, 1615-B Oberlin Road, PO Box 31345, Raleigh NC 27622; (919) 828-1218 v/t

Registry of Interpreters for the Deaf, Inc., 8630 Fenton St., Suite 324, Silver Spring MD 20910; (301) 608-0050 v/t; (301) 608-0508 fax

Self Help for Hard of Hearing people, 7910 Woodmont Ave., Suite 1200, Bethesda MD 20814 (301) 657-2248 v; (301) 657-2249 t; (301) 913-9413 fax

Journals

American Annals of the Deaf, KDES PAS-6, 800 Florida Ave NE, Washington DC 20002-3695 (202) 651- 5000 v/t

Journal of Deaf Studies and Deaf Education, National Technical Institute for the Deaf, Rochester Institute of Technology, 52 Lomb Memorial Drive, Rochester NY 14623; (716) 475-6580 (fax); *jdsde@rit.edu* (email)

Journal of Speech and Hearing Research, American Speech Language Hearing Association, 10801 Rockville Pike, Rockville MD 20852; (800) 638-8255 v/t

Preview, KDES Pre-College National Mission Programs, 800 Florida Ave NE, Washington DC 20002-3695; (202) 651-5000 v/t

Volta Review, Alexander Graham Bell Association for the Deaf, 3417 Volta Place NW, Washington DC 20007; (202) 337-5220 v/t

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Encopresis

A Parent's Guide

by Michael B. Brown, Ph.D., NCSP
East Carolina University

Overview

Encopresis (sometimes called soiling) is when a child repeatedly has bowel movements where they are not supposed to have them, or does not control bowel movements after the age of 4. It is much more common with boys than girls, and about 1 in 100 children have this difficulty. Encopresis usually occurs during the daytime, although it may also occur at night. Children may never have developed control of their bowel movements (called "primary" encopresis), or may have once had appropriate toileting skills and later develop problems with bowel movements (called "secondary" encopresis).

Some children withhold their bowel movements (called the "retentive" type of encopresis), which results in constipation and an "overflow" of liquid bowel. Retentive encopresis is the most common type. The child doesn't mean to soil, but the soiling occurs because the child has withheld the bowel movement. Sometimes a child may have the "nonretentive" type of encopresis. The child will have bowel movements in their clothing and/or in inappropriate places such as closets or behind furniture. This type of encopresis is frequently caused by emotional problems or family stress, and may require different treatment from the retentive type. Some experts also classify encopresis as "with" or "without constipation." This guide will focus on the retentive type of encopresis, as it is the most common. However, many of the ideas here may be helpful if your child has other types of encopresis.

What Causes Encopresis?

Usually there are a combination of factors that cause children to withhold their bowel movement. Chronic constipation is characteristic of about 80% of children with encopresis. The most common causes of constipation are 1) insufficient roughage or bulk in the diet; 2) a very bland diet; and 3) insufficient intake of liquids. Younger children may be afraid of the toilet for fear of falling in or being "flushed down" and so avoid toileting. Children who have had painful bowel movements may try not to have a bowel movement because they are afraid it will hurt. Some children may be too interested in what they are doing to stop and use the toilet. If toilet training is too strict the child may withhold the bowel movement as a way to prove that he or she is independent. Family stress or changes may also be a factor. Sometimes children are embarrassed to go to the bathroom at school and so try to hold their bowel movements until they get home. Once children begin to withhold bowel movements, they become constipated. Large amounts of hardened stool remain in the colon. The child no longer feels the urge to go to the toilet. When he does use the toilet the large, hard bowel movement is usually painful, causing him to withhold his bowel to avoid pain. Persistent constipation leads to the leakage of liquid bowel, which soils the child's underwear. A cycle is started where withholding leads to further withholding and soiling due to leakage. This soiling occurs even while the child tries not to soil.

What Are Some of the Effects of Encopresis?

Encopresis may cause increased stress within the family. Parents may become upset and resentful of the child. Brothers and sisters may also become angry, embarrassed or tease the child about the toileting problems. Family activities may be limited out of fear of the encopresis occurring away from home. If the encopresis occurs frequently or is unpredictable, it may affect how the child gets along with friends. Friends may make fun of the child or may not want to play with him, especially if they think the child is dirty or "babyish". Children may avoid being around others for fear that they will soil themselves.

Children with encopresis often feel ashamed and embarrassed. They are often scared by their lack of control over their bowel movements. They usually feel different from others, as they are not aware that this occurs in other people. They often are afraid of people finding out they have soiled, and may be depressed or anxious. All of this results in the child feeling very badly about themselves. Parents or other adults may blame the child, make fun of her, or tell her that she only soils to "get attention".

What Can Parents Do?

If your child has difficulty becoming bowel trained after 4, or has been trained and then develops encopresis, the parent should consult a physician. The physician can make sure that the encopresis is not caused by a physical or medical problem. The physician can also help you decide if you and your child need further help in dealing with the encopresis from a mental health professional. If so, the physician or school psychologist can help you choose a mental health professional who can be of help to you. Your physician will also be involved when medical treatment of encopresis is necessary (usually for the retentive type of encopresis). The medical treatment may include laxatives, enemas and changes in the child's diet.

The treatment of encopresis usually involves many different types of interventions. You should make sure that you understand the interventions recommended, and your part in the treatment plan. Here are some things parents can do to help:

- ***Sort out your own feelings so you can stay in control.*** Being mad and yelling only will make matters worse. Try not to be discouraged and focus on what you can do to help.
- ***Work on improving your relationship with your child.*** Have some special time with your child each day, and try to build in some family fun time.
- ***Emphasize the use of rewards rather than punishment.*** Don't use nagging or ridicule to try to change the situation.
- ***Follow the recommendations of the physician for diet and medical treatment***.
- ***Make sure your child has the necessary toileting skills*** and that they are reminded to use them. Some children do not know how to appropriately clean themselves or do not pay attention to whether they are clean after a bowel movement.
- ***Using reward systems:*** Most treatment programs will involve the use of a reward system for going to the toilet and for clean underwear. Make sure that you understand the reward system and your role in the system. Be sure to closely follow the plan. Give the agreed upon reward and a verbal reward as soon as you find out that the child has clean underwear or has used the toilet.
- ***Work with school personnel:*** Talk with your child's teacher, school counselor and school psychologist if encopresis is a problem at school. Teachers can be especially helpful and may play an important role in the treatment plan. They can also help to prevent embarrassment or ridicule if soiling occurs at school. Providing an extra change of clothes at school, private bathroom time, and allowing the child to use the bathroom when needed will also be helpful. Talk with the treatment provider and the teacher to see if it is necessary to have an excuse from gym or physical activity if accidents occur during these times.
- ***Don't blame yourself:*** Try not to feel ashamed or angry if the treatment of your child involves counseling for you or the rest of the family. It doesn't mean you are to blame.
- ***Be patient!*** Recognize that encopresis sometimes takes a while to get better, and your child may have relapses along the way. Try to be patient and stay positive.

Resources for Parents

Azrin, N. (1989, reissue). *Toilet training in less than a day.* New York: Pocket Books.

Faull, J. (1996). *Mommy! I have to go potty!: A parent's guide to toilet training.* Raefield-Roberts.

Rogers, F. & Judkis, J. (1997, reprint edition). *Going to the potty.* Paper Star. (Ages 4-8)

Schaefer, C.E. (1997). *Toilet training without tears.* Signet Books.

Spock, B., & Rothenberg, M. B. (1992). *Dr. Spock's Baby and Child Care.* New York: Pocket Books.

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Encopresis

A Teacher's Guide

by Michael B. Brown, Ph.D., NCSP
East Carolina University

Overview

Encopresis (sometimes called soiling) is when a child repeatedly has bowel movements in inappropriate places or does not control bowel movements after the age of 4. It is much more common with boys than girls, and about 1% of children have this problems. Encopresis most frequently occurs during the daytime (diurnal encopresis), although it may also occur at night (nocturnal encopresis). Children with encopresis may never have developed control of their bowel movements (primary or continuous encopresis), or may have once had appropriate toileting skills and later have inappropriate bowel movements (secondary or discontinuous encopresis).

Some children with encopresis withhold their bowel movements (retentive type), which results in constipation and an "overflow" of liquid bowel. This is the most common type of encopresis. The child doesn't mean to soil, but the soiling occurs as a result of withholding stool. Occasionally you may have a student with the nonretentive type of encopresis. The child will have bowel movements in their clothing and/or in inappropriate places such as closets. Frequently this type of encopresis is caused by emotional or family problems, and may require different treatment from the retentive type. Encopresis can also be classified as occurring with or without constipation. This guide will focus on the retentive type of encopresis, as it is the most commonly encountered in the classroom. However, many of the ideas here may be helpful if a student has nonretentive type encopresis.

What Causes Encopresis?

While there are some medical conditions that can cause encopresis, there is no one single cause. Usually there are a number of factors that lead to the child withholding their bowel movement. Chronic constipation is characteristic of about 80% of children with encopresis. The most common causes of constipation are 1) insufficient roughage or bulk in the diet; 2) a very bland diet; and 3) insufficient intake of liquids. Younger children may be afraid of the toilet for fear of falling in or being "flushed down" and so avoid toileting. Children who have had painful bowel movements may try not to have a bowel movement because they are afraid it will hurt. Some children may be too interested in what they are doing to stop and use the toilet. If toilet training is too strict the child may withhold their bowel movement as a way to prove they are independent. Family stress or changes may also be a factor. A prolonged medical illness may trigger a recurrence of symptoms in a child who is prone to encopresis. Some children are embarrassed to go to the bathroom at school and so try to hold their bowel movements until they get home. Children who have Attention Deficit Hyperactivity Disorder may also be more prone toward encopresis.

Once the child begins to withhold bowel movements, constipation sets in. Large amounts of hardened stool remain in the colon. The child no longer feels the urge to go to the toilet. When he does use the toilet the large, hard bowel movement is usually painful, leading to further withholding. Persistent constipation leads to the leakage of liquid bowel which soils the child's underwear. A cycle is started where withholding leads to further withholding and later soiling due to leakage, while the child tries not to soil.

What Are Some of the Effects of Encopresis?

Encopresis frequently results in increased stress within the family. Parents may become upset and resentful of the child. Siblings may tease the child about the toilet problems. Family activities may be eliminated for fear that encopresis will occur while away from home. If the encopresis occurs frequently or is unpredictable, it may affect the child's relationship with peers. Peers may ridicule the student or may isolate themselves from the child, especially if they view the behavior as dirty or as "babyish". Children with encopresis may also restrict their social activities out of fear of an encopretic event.

Children with encopresis often feel ashamed and embarrassed. They are frightened by their lack of control over their bowel movements. They frequently are not aware that this occurs in other children, so they feel very different. They often live in fear of being discovered, and may suffer from anxiety and depression. Adults who find out about the child's soiling may blame the child, make fun of her, or tell her that she only soils to "get attention". All of this has a significant impact on the child's self-concept and self-esteem.

What Can Teachers Do?

Usually a teacher will find out from a child's parent that the child has encopresis. If a student has problems with bowel movements during school, you should make every effort to protect the dignity of the child. You should notify the parent about the difficulty, and if it persists, arrange for a meeting with the parent along with the school psychologist or school counselor. Parents should consult a physician if their child has difficulty becoming bowel trained after age four, or has been trained and then develops encopresis. The physician can make sure that the encopresis is not caused by a physical or medical problem, and provide any necessary medical treatment. The physician can also help the parent decide if the child needs help from a mental health professional in dealing with the encopresis. If so, the physician, school psychologist or school counselor can help the parent choose a qualified mental health professional.

The treatment of encopresis may involve several different interventions. Medical treatment, such as laxatives, enemas or change in diet are often used. Behavioral interventions that emphasize positive reinforcement for appropriate toileting are often used in conjunction with medication. Children may benefit from education about good toilet habits and scheduled toilet breaks. In some cases family counseling may be recommended. Parents should make sure that they understand the recommended interventions and their role in the treatment plan. Here are some things that teachers can do to assist children who have encopresis:

- ***Sort out your own feelings*** so you can stay in control. Being angry or repulsed only make matters worse. Try not to be discouraged and focus on what you can do to help.
- ***Support and encourage the parent,*** who may feel angry, embarrassed or ashamed about the situation. Encourage parents to follow through with the treatment plan, and have them contact the treatment provider if they do not understand the treatment or their role in the intervention plan.
- ***Make sure that you understand the intervention plan*** and what your role is in the plan if encopresis occurs at school. For young children, most treatment programs will involve the use of a reward system for going to the toilet and for clean underwear. Be sure to closely follow the plan. Give the agreed upon reward (such as a star on a chart) and a verbal reward as soon as you find out that the child has clean underwear or has used the toilet. Provide feedback to the parent and treatment provider.
- ***Don't overfocus on the soiling behavior.*** Help the child to do things that he or she does well. Provide plenty of positive feedback for successes.
- ***Protect the child*** from ridicule and embarrassment. Swift action to quell teasing is important. You should also try to help the child "cover up" any accidents that occur in public.

- ***Specific supports,*** such as providing an extra change of clothes at school, private bathroom time and allowing the child to use the bathroom when needed will also be helpful if recommended by the treatment provider. An excuse from gym or physical activity may be helpful if encopresis occurs during these times.
- ***Be patient.*** Recognize that encopresis sometimes takes a while to be resolved, and the child may have relapses along the way. Try to be patient and stay positive.

Resources for Teachers

Levine, M. D. (1992). Encopresis. In Levine, M. D., Carey, W. B., & Crocker, A. C. (Eds.). *Developmental-Behavioral Pediatrics.* Philadelphia: W. B. Saunders.

Spock, B., & Rothenberg, M. B. (1992). *Dr. Spock's Baby and Child Care.* New York: Pocket Books.

Steege, M. (1997). Encopresis and enuresis. In G. Bear, K. Minke & A. Thomas (Eds.), *Children's Needs II: Development, problems and alternatives* (pp 879-885). Bethesda, MD: National Associaton of School Psychologists.

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Enuresis

A Guide for Parents

by T. Steuart Watson, Ph.D.
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Background

Bedwetting, or "enuresis," is a fairly common but annoying (and embarrassing) problem among young and school-age children. There are three types of enuresis — diurnal, nocturnal and mixed. Diurnal enuresis refers to failure to control the bladder during the daytime and nocturnal enuresis refers to failure to control the bladder while asleep (bed wetting). Mixed enuresis refers to cases where there is both daytime and nighttime wetting, which is a relatively rare occurrence. Nocturnal enuresis is far more common than either diurnal or mixed enuresis. Enuresis that occurs in children who have never been successfully toilet trained is called primary enuresis; enuresis that occurs in children after a six-month period of urinary continence is called secondary enuresis. Enuresis is not diagnosed until age five, or in the case of children with developmental disabilities, when their developmental age reaches five. Children with enuresis may wet their clothes or bed as infrequently as twice a week or as often as every day/night. Although it may seem that enuresis runs in families, it is unclear whether enuresis is inherited or whether parents who were "bedwetters" are more tolerant of their child's wetting and lack of toileting skills.

Development

Approximately 25% of boys and 15% of girls are bedwetters at age six. By age 12, only 8% of boys and 4% of girls still wet the bed. By adolescence, only about 1% of children continue wetting at night. Thus, if given sufficient time, most children will "grow out of" wetting their bed. The key question is how long parents are willing to wait for children to stop bedwetting on their own.

Medical causes: The two most common medical causes of enuresis are urinary tract infections and diabetes mellitus. The first step is to rule these out by a simple urinalysis performed at the doctor's office. Even when urinary tract infections are successfully treated by antibiotics, about 60% of children continue wetting the bed. Other physical conditions that can cause enuresis include epilepsy, urinary tract abnormalities, bladder instability and spinal bifida occulta. Generally speaking, unless there is reason to strongly suspect a physical defect as the cause of enuresis, there is usually no reason to undergo invasive procedures to identify a physical problem. In rare cases, secondary enuresis may be caused by extremely stressful or traumatic events (e.g., death of a parent, natural disaster). It is important to note, however, that enuresis is not indicative of an emotional disturbance, even in cases where urinary continence skills have been lost (i.e., secondary enuresis). If emotional problems are present, it is more likely that they are a result rather than a cause of enuresis. In the absence of infection, disease or physical problems, enuresis is best thought of as a problem where the child has not learned to attend and respond to the cues associated with having a full bladder and the urge to urinate.

What Can I Do as a Parent?

First, parents should consult with their pediatrician or family physician to rule out a medical cause for the enuresis. The next step is to consult a psychologist with experience in treating enuresis. Treatment falls into one of two general categories: Drugs and behavioral interventions.

Drug treatment. The two drugs used to treat enuresis are *imipramine*, an antidepressant, and *DDAVP, or desmopressin*, an antidiuretic. Imipramine is usually prescribed in doses between 25 and 75mg to be given one hour before bedtime. Despite the rapid initial reduction in bedwetting, only about 10% of children taking imipramine have long-term success and there are side effects to consider.

DDAVP is administered intranasally at bedtime. Studies have shown that fewer than 25% of children who take the drug stop wetting the bed. Like imipramine, when DDAVP is discontinued, the bedwetting returns. In addition, it is not as effective in younger children or in children who have frequent accidents. Another drawback is that the DDAVP is very expensive. On the positive side, it works as quickly as imipramine and has fewer side effects.

Behavioral interventions. A number of effective behavioral interventions are available for treating enuresis, including the urine alarm (a modern version of the bell and pad), retention control training, positive reinforcement and responsibility training. By far, the single most effective method is the *urine alarm*, with a success rate of 75%. A moisture sensitive switch is attached to the child's underwear, which rings an alarm as soon as the child begins to urinate. The child then awakens, or is awakened by the parents, and urinates in the toilet. During the first few weeks of using the alarm, it is not unusual for the child to completely urinate before awakening. Consistent use of the alarm, along with *positive reinforcement* for dry nights, usually produces changes in frequency of bed wetting after several weeks.

A useful adjunct to the urine alarm and positive reinforcement is *responsibility training*, which involves two aspects: (a) removing diapers or pull-ups at night and (b) assigning children age-appropriate duties associated with their bedwetting (in younger children, removing the sheets and changing pajamas; in older children, washing the sheets). Responsibility training is not intended as punishment but rather as acknowledgment of the child's maturity and ability to overcome bedwetting.

Retention control training (RCT) increases bladder capacity by having children drink large amounts of fluid (e.g., 16 oz. of water) at one time each day and delaying urination for as long as possible. RCT has resulted in a success rate of 50% and may be used in conjunction with the urine alarm.

It is extremely important that parents not punish or shame their child in an attempt to cure bedwetting. Children do not wet their bed intentionally nor are they being manipulative or lazy. They have simply not learned to awaken when their bladders are full. The job of parents, with the assistance of trained professionals, is to teach the child to awaken to the sensation of a full bladder and to urinate in the toilet. Although there are several self-help books available to parents, it is recommended that a *psychologist* be involved with treatment of enuresis because of the complexity of treatment and the various difficulties associated with implementing some aspects of treatment.

Self-Help Books

Azrin, N. H., & Besalel, V. A. (1979). *A parent's guide to bed wetting control.* New York: Simon and Schuster.

Houts, A. C., & Liebert, R. M. (1984). *Bed wetting: A guide for parents and children.* Springfield, IL: Thomas.

Urine Alarm

Star/Child Labs, P O Box 404, Aptos, CA 95001-0404
Phone: (408) 662-2659, Fax: (408) 688-8699

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Fetal Alcohol Syndrome and Fetal Alcohol Effects

A Parents' Guide

**by Kayreen A. Burns, Ph.D.
and Agnes E. Shine, Ph.D., NCSP
Barry University (FL)**

Background

The impact of alcohol on the developing fetus has been reported for centuries. It was not until the early 1970's that the negative consequences of prenatal exposure to alcohol were defined as a life-long syndrome. *Fetal Alcohol Syndrome (FAS)* is a cluster of physical and cognitive deficits found in children whose mothers consumed alcohol while pregnant. A diagnosis of FAS requires the mothers' acknowledgment of alcohol use and features from the following three clusters: 1) pre-or postnatal growth below the 10th percentile; 2) specific head and facial abnormalities; and 3) central nervous system deficits (i.e. developmental delays, mental retardation). If the child meets the criteria for only one or two of the above three clusters and the mother confirms a history of alcohol use while pregnant, a diagnosis of *Fetal Alcohol Effects (FAE) or Possible Fetal Alcohol Syndrome (PFAS)* is given. When the characteristics of FAS are present, but a history of prenatal maternal alcohol use is not acknowledged, the child is diagnosed as *Possible Fetal Alcohol Syndrome or Possible Fetal Alcohol Effects.*

FAS is the leading cause of mental retardation in the western world. Conservative population statistics estimate that 2-3 infants out of every 1000 receive a formal diagnosis of FAS each year. This means that there are about 5,000 new cases diagnosed per year. Presently, there are about 70,000 children under the age of 18 diagnosed as FAS. The prevalence rate for FAE is considered to be at least 3-6 times higher than that of FAS. Since mothers must acknowledge alcohol consumption as part of the diagnosis of FAS/FAE, many children are undiagnosed because the mother denies drinking during pregnancy. Another obstacle in diagnosis is that physicians fail to recognize the cluster of symptoms. Therefore, FAS/FAE may occur at a much higher rate than reported. In populations where mothers are at higher than average risk, FAS/FAE rates could be much higher than the rate in the general population.

Factors related to FAS/FAE: Not all children born to mothers who consume alcohol while pregnant have FAS or FAE. At the present time, the amount of alcohol that is needed to produce FAS/FAE is unclear. It appears that the age of the mother, possibly due to a longer history of alcohol use, is related to FAS/FAE. Mothers who previously had a child with FAS have about a 75% chance of having another child with FAS. Research suggests that each time an alcohol abusing mother has a child, the severity of the effects of alcohol exposure increases. Most children diagnosed as FAS do not live with their mothers. Frequently, these children are placed in foster care, care of a relative or are adopted due to neglect, abuse or maternal death.

Although drinking at any time during pregnancy can harm the developing fetus, it seems to have specific negative effects during each trimester. Exposure during the first three months results in physical abnormalities and growth retardation. If it occurs during the second trimester, it is likely to have negative effects on both growth and intellectual development. The primary target during the last trimester of the pregnancy is intellectual development.

Prevention: Abstinence from alcohol prior to and throughout pregnancy is the only sure way to prevent FAE and FAS. Because the critical amount of alcohol that will produce abnormalities is unknown and because alcohol appears to have negative effects at different stages of prenatal development, the U.S. Surgeon General recommends complete abstinence during pregnancy.

Characteristics of FAS/FAE Infants, Children and Adolescents

The Infant and Preschooler: Among the most striking features of newborns with FAS/FAE is their small and often scrawny body and even smaller head. Their appearance has been described as elf-like. These babies have an extended period of weight loss after birth, and are prone to not gain weight as do other babies. During the newborn period, they display jitteriness, irritability and tremulousness. They are reported to have a weak suck and are poor feeders, which may cause them to be under-nourished. They are also easily excitable and have erratic and fitful sleep patterns. During infancy, poor motor development is often the first noticeable sign of delay. They have weak muscle tone and so are slower than normal to master motor milestones such as rolling, sitting, walking, running and peddling a tricycle. Due to their weak hand grasp, fine motor development is also delayed. As they move into toddlerhood and the preschool years, their motor delays express themselves in clumsy gross motor movements and poor drawing and coloring.

Academic Development: Children diagnosed FAS/FAE have reduced intellectual functioning. As a result, many are placed in special education classes for the mentally handicapped or learning disabled. Signs of academic difficulty begin in the preschool years. They are frequently delayed in entry into kindergarten or first grade, or they repeat kindergarten because of delays in speech, motor development, impulsivity, distractibility and hyperactivity. Frequently they are placed in special education during the primary grades. Poor attention span, longer reaction time and poor skills for recalling information interfere with learning. As they move into middle school, their poor organization and rigid approach to problem solving increases their struggle to learn more abstract materials. They have more problems with mathematics than they do with reading and spelling, although they have a great deal of difficulty recalling verbal material and holding the information in their short term memory. Achievement peaks at 12-15 years of age, so the transition to middle school and high school is very challenging and frustrating for both child and parents.

Language Development: During the preschool years, FAS/FAE children are very talkative. Because they are small in stature, they appear younger than they are. Therefore, the delays in their verbal skills are often not apparent during preschool years. However, even though they use verbal language, they frequently have difficulty communicating effectively. In addition to immature language usage, they have deficits in conversation skills. They are intrusive and frequently ignore the message presented to them in a conversation. Due to inattentiveness and poor language skills, they may have difficulty answering even a simple, direct question.

Social Development: Preschool FAS/FAE children are socially engaging, outgoing, affectionate and seem to have an insatiable need for bodily contact. They prefer people to objects. As they get older, they usually remain cooperative and compliant. They have a naivete that can threaten their safety. They also have reduced adaptive skills so they do not learn from experience. With their lack of good judgment, they can be intrusive or unrestrained and have difficulty seeing cause-effect relationships. As a result, they have difficulty making and keeping friends and participating in group activities. Adolescents are frequently socially isolated and have poor peer relationships. As adults, they are unlikely to live independently; they have a high likelihood of being taken advantage of and they are at high risk for alcohol abuse.

Behavior Problems: FAS/FAE preschoolers are especially hyperactive, impulsive, irritable and have deficits in attention. As they enter school, their poor concentration, short attention span and inattentiveness interfere with academic and social development and these deficits are at the root of many of their behavior problems. When the child displayed behavioral difficulties, parent(s) and caregiver(s) should carefully observe the child's behavior, since acting out may be the result the child's frustration with his/her inability to complete a present or prior task. Because of their high level of activity and inattention, these children may be diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD).

Additional Problems Associated with FAS/FAE: Research on FAS indicates that there is an increased likelihood for a number of other problems related to prenatal alcohol exposure: congenital heart defects; seizures; joint and limb malformations; strabismus; dental problems; chronic ear infections; eating disorders; stereotypic behaviors; sleep problems; bed wetting at school age; phobias; and abnormal habits.

What Can I Do as a Parent?

1. Interact with your child and encourage verbal communication. This will stimulate language development.
2. Provide an extremely high degree of structure. Your child will benefit from consistent daily routines (e.g., a set evening routine and bedtime).
3. Rules should be simple, clear and concise, and they should be consistently enforced.
4. Individualized instructions will help your child learn chores and self help skills. Each required task should be broken into small, sequential steps.
5. Safety and caution should be stressed because your exceptionally friendly child may have poor social judgment. Close monitoring of activities may be necessary.
6. Homework should be done in a quiet room free from distractions. Frequent short breaks should be programmed into the study period. A simple kitchen timer set for 5, 10 or 15 minutes can be used to structure these study periods and breaks.
7. Reward your child frequently (verbal praise, hug, smile) for appropriate behaviors rather than punish him/her for inappropriate deeds.
8. Provide your child with frequent examples of appropriate social behaviors. The FAS/FAE child does not benefit from past experiences of rejection or isolation when he/she behaved intrusively or inappropriately with peers.

Resources

Davis, D. (1994). *Reaching out to the children with FAS/FAE.* New York: The Center for Applied Research in Education.

Dorris, M. (1989). *The broken cord: A family's ongoing struggle with fetal alcohol syndrome.* New York: Harper & Row.

Wentz, T., & Larson, J. (1993). *The FAS child: A primer for teachers.* University of North Dakota, Grand Forks. (ERIC Document Reproduction Service No. ED 367 114).

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Fetal Alcohol Syndrome and Fetal Alcohol Effects

A Teachers' Guide

by Kayreen A. Burns, Ph.D.
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Background

The impact of alcohol on the developing fetus has been reported for centuries. It was not until the early 1970's that the negative effects of prenatal exposure to alcohol were formally documented and the consequences were defined as a life-long syndrome. *Fetal Alcohol Syndrome (FAS)* is a cluster of physical and cognitive deficits found in children whose mothers consumed alcohol while pregnant. A diagnosis of FAS requires the mothers' acknowledgment of alcohol use and features from the following three clusters: 1) pre-or postnatal growth below the 10th percentile; 2) specific head and facial abnormalities; and 3) central nervous system deficits (i.e. developmental delays, mental retardation). If the child meets the criteria for only one or two of the above three clusters and the mother confirms a history of alcohol use while pregnant, a diagnosis of *Fetal Alcohol Effects (FAE)* or Possible Fetal Alcohol Syndrome (PFAS) is given. When the characteristics of FAS are present, but a history of prenatal maternal alcohol use is not acknowledged, the child is diagnosed as *Possible Fetal Alcohol Syndrome or Possible Fetal Alcohol Effects.*

FAS is the leading cause of mental retardation in the western world. Conservative population statistics estimate that 2-3 infants out of every 1000 receive a formal diagnosis of FAS each year. This means that there are about 5,000 new cases diagnosed per year. Presently, there are about 70,000 children under the age of 18 diagnosed as FAS. The prevalence rate for FAE is considered to be at least 3-6 times higher than that of FAS. Since maternal confirmation of alcohol consumption is a necessary component in diagnosing FAS/FAE, many children are undiagnosed due to denial of prenatal alcohol consumption. Another obstacle in diagnosis is that physicians fail to recognize the cluster of symptoms. Therefore, the prevalence rate FAS/FAE may be much higher than reported. In populations where mothers are at higher than average risk, FAS/FAE rates could be much higher than the rate in the general population.

Factors related to FAS/FAE: Not all children born to mothers who consume alcohol while pregnant have FAS or FAE. At the present time, the amount of alcohol that is needed to produce FAS/FAE is unclear. It appears that the age of the mother, possibly due to a longer history of alcohol use, is related to FAS/FAE. Mothers who previously had a child with FAS have about a 75% chance of having another child with FAS. Research suggests that each time an alcohol abusing mother has a child, the severity of the effects of alcohol exposure increases. Less than 10% of FAS children grow up in the home of their mother. Many are removed due to neglect, abuse or death of the mother. Therefore most of these children are in foster care, raised by a relative or adopted.

Although drinking at any time during pregnancy can harm the developing fetus, it seems to have specific negative effects during each trimester. Exposure during the first three months results in physical abnormalities and growth retardation. If it occurs during the second trimester, it is likely to have negative effects on both growth and intellectual development. The primary target during the last trimester of the pregnancy is intellectual development.

Characteristics of FAS/FAE Infants, Children and Adolescents

The Infant and Preschooler: Among the most striking features of newborns with FAS/FAE is their small and often scrawny body and even smaller head. Their appearance has been described as elf-like. These babies have an extended period of weight loss after birth, and are prone to 'failure to thrive'. During the newborn period they display jitteriness, irritability and tremulousness. They are reported to have a weak suck, are poor feeders, have erratic and fitful sleep and are hyperexcitable. During infancy poor motor development is often the first noticeable sign of delay. They are hypotonic and are slower than normal to master motor milestones. They have a weak grasp and so fine motor development is also delayed. As they move into toddlerhood and the preschool years their motor delay expresses itself in clumsy gross motor movements and delayed drawing and coloring.

Academic Development: Children diagnosed FAS/FAE have reduced intellectual functioning. As a result many are placed in classes for the mentally handicapped or learning disabled. Signs of academic difficulty begin in the preschool years. They are frequently delayed in entry into kindergarten or first grade, or they repeat kindergarten because of delays in speech, motor development, impulsivity, distractibility and hyperactivity. Frequently they are placed in special education during the primary grades. Poor attention span, longer reaction time, and poor memory skills for recalling information interfere with learning. As they move into middle school, their poor organization and rigid approach to problem solving compounds their struggle to learn more abstract materials. They have more difficulty with mathematics than they do with reading and spelling, although they have a great deal of difficulty recalling verbal material and holding information in working memory so they can manipulate it.

Research indicates that the FAS/FAE child can remember as well as other children. Therefore, their memory problems are related to encoding new material rather than retrieval of material already in long term memory. These children learn at a slower rate and learn less academic material than other children. However, once they learn a concept they retain it. Achievement peaks at 12-15 years of age so the transition to middle school and high school is very difficult for the adolescent, parent and teacher.

Language Development: During the preschool years, FAS/FAE children are very talkative. Because they are small in stature, they appear younger than they are. Therefore, the lack of richness in their frequent verbal communication is not recognized. Even though they use verbal language, they frequently have difficulty communicating effectively. In addition to limited grammatic complexity they have deficits in pragmatic skills. They are intrusive and frequently ignore the message presented to them in a conversation. Consequently, they are frequently unable to give appropriate answers to questions.

Social Development: Preschool FAS/FAE children are socially engaging, outgoing, affectionate and seem to have an insatiable need for bodily contact. They prefer people to objects. As they get older, they remain cooperative and compliant. They acquiesce with a naivete that can threaten their safety. They also have reduced adaptive skills so they do not learn from experience. They make poor judgments, can be intrusive or unrestrained and have difficulty seeing cause-effect relationships. As a result they have difficulty making and keeping friends and participating in group activities. Adolescents are frequently socially isolated and have poor peer relationships. As adults, they are unlikely to live independently, they have a high likelihood of being taken advantage of and they are at high risk for alcohol abuse.

Behavior Problems: FAS/FAE preschoolers are especially hyperactive, impulsive, irritable and have deficits in attention. As they enter school their poor concentration, short attention span, and inattentiveness interferes with academic and social development and these deficits are at the root of many of their behavior problems. These symptoms may lead to a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). When the child displays behavioral difficulties in the classroom, the teacher should carefully observe the child's behavior since the acting out may be a result of the child's frustration with their failure understand or complete an activity. However, when they exhibit hostility and destructiveness the cause is more likely related to a difficult home rather than school environment.

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Additional Problems Associated with FAS/FAE: The literature on FAS indicated that there is an increased likelihood for a number of other problems related to prenatal alcohol exposure: congenital heart defects; seizures; joint and limb malformations; strabismus; dental problems; chronic ear infections; eating disorders; stereotypic behaviors; sleep problems; bed wetting at school age; phobias; and abnormal habits.

Interventions

Individualized structured programs: Possibly the best intervention for these children is early detection and intervention since many will need individualized instruction. Classrooms with a high degree of structure and routine, clear expectations and consistent application of classroom rules seems to work best for FAS/FAE children, while strategies must be creative and flexible. These children often benefit from small classrooms where change and stimulation are minimal with lots of one-to-one attention and supervision. Visual information (pictures and charts) should support all verbally presented information.

Behavioral programs are extremely successful because they specify specific behavioral task requirements and identify immediate rewards for success. The children should be rewarded for their efforts rather than punished for their mistakes. Although children with FAS/FAE are talkative, remember that their language skills may be poorly developed and they may fail to comprehend basic (e.g., under, over, between) and abstract (e.g., happy, sad) concepts. Behavioral strategies that promote independence should be emphasized.

Break down tasks, provide repetition: Breaking down tasks into small parts and using a multimodal approach is helpful when teaching new concepts. Since these children have difficulty learning from experience, they will need more examples and practice. When teaching a new task, provide constant repetition and overlearning since these children have difficulty with short-term memory. Playing simple memory games may be helpful.

Teach functional skills: Organizational skills training is essential for children with FAS/FAE. Social skills training in a variety of settings helps with peer relationships. As the child matures, teaching life skills and vocational skills may be appropriate.

Communicate with parents: Constant contact with parent(s) or caregiver(s) is essential. School personnel can provide families with information about counseling services (for parents and families) and with information about FAE and FAS to help parents understand the child's limitations and realistic expectations.

Resources

A systemic approach to dealing with fetal alcohol and other drug affected children in an educational setting, participant workbook. (1991). From the Western Regional Center Drug-Free Schools and Communities Project: Northwest Regional Education Laboratory, 101 SW Main St., Suite 500, Portland, OR 97204, 1-800-547-6339.

Batshaw, M., & Perret, Y. (1992). *Children with disabilities* (3rd ed.). Baltimore: Paul H. Brookes.

Davis, D. (1994). *Reaching out to the children with FAS/FAE.* New York: The Center for Applied Research in Education.

Dorris, M. (1989). *The broken cord: A family's ongoing struggle with fetal alcohol syndrome.* New York: Harper & Row.

Galanter, M. (Ed.). (1991). *Recent developments in alcoholism: Vol. 9. Children of alcoholics: Genetic disposition, fetal alcohol syndrome, vulnerability to disease, social and environmental issues.* New York: Plenum Press.

Phelps, L., & Grabowski, J. (1992). Fetal Alcohol Syndrome: Diagnostic features and psycho-educational risk factors. *School Psychology Quarterly, 7(2),* 112-128.

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Schenck, R., Cale, J., & Medina, C. (1994). *Fetal alcohol syndrome (FAS), fetal alcohol effects (FAE): Implications for rural classrooms.* New Mexico State University, New Mexico; Department of Special Education/Communication Disorders. (ERIC Document Reproduction Service No. ED 369 602).

Streissguth, A., & Burgess, D.M. (1992). Fetal alcohol syndrome and fetal alcohol effects: Principles for educators. *Phi Delta Kappan, 74,* 24-30.

Wentz, T., & Larson, J. (1993). *The FAS child: A primer for teachers.* University of North Dakota, Grand Forks. (ERIC Document Reproduction Service No. ED 367 114).

Additional intervention strategies and resources were provided by Tracy Myers and Almaree Williams, students in the graduate school psychology program at the University of Wisconsin-Milwaukee.

NATIONAL
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Physical Abuse

A Handout for Parents

by William Pfohl, Psy.D., NCSP
and M. Jennifer Allen and Shannon Chesser
Western Kentucky University

Introduction

Currently in this country, over 30 children per every 1000 are reported abused; over 3 children per day die from physical abuse or neglect. Reporting of abuse has increased 45% since 1987; twenty-five percent (25%) involve physical abuse.

Parents and care givers do not always know that they are being abusive or neglectful. Few adults actually intend to hurt or neglect children. Sometimes a caretaker just does not know a better way to discipline a child. Many times an adult is just too frustrated with life and takes it out on a child. Most abuse occurs under times of increased stress. *Any parent has the potential to be abusive, under the "right" circumstances.*

Since children are our nation's future, it is important that we prevent this senseless harming and protect one of our greatest assets, our children. It is important to know what child abuse is, how we can spot abuse, and where to turn for help. Prevention begins with you.

What Is Physical Abuse?

The National Committee to Prevent Child Abuse defines physical abuse as a non-accidental injury or pattern of injury to a child. Federal Public Law 104-235 (1996) defines physical abuse as: "the infliction of physical injury as a result of punching, beating, kicking, biting, burning, shaking, or otherwise harming a child. The parent or caretaker may not have intended to hurt the child, rather the injury may have resulted from over-discipline or physical punishment." (Section 111; 42 U.S.C. 5106g). This law applies to anyone under the age of 18.

Examples of physical abuse include:

- hitting or slapping
- beating with a belt, shoe, stick/switch or other object
- burning a child with matches, cigarettes, stove or other hot object
- scalding a child with water that is too hot
- pulling a child's hair out
- breaking a child's arm, leg, or other bones
- not letting a child eat, drink or use the bathroom
- shaking a child violently, particularly an infant or toddler
- grabbing a child's body parts (i.e., ears, nose, etc.) and twisting

What is the difference between discipline and abuse?

All children need discipline. Discipline means to teach a child to behave appropriately . Punishment is an effort to stop or suppress a behavior. Punishment never changes a behavior but only stops it for a little while. Typically physical punishment is used to deal with dangerous behavior, such as running in a parking lot, or placing an object in a light socket. Punishment must be reasonable for the situation and understandable to the child, and not put a child's health in danger. The intent of punishment is to make the child understand a wrong behavior — not to instill unreasonable fear. It is abuse when the parent's actions are excessive and physically injure the child.

Discipline provides education to children or youth about their behaviors. Children need to know *what is the right or correct thing to do.* Children should know what the appropriate consequences will be if the event they break the rules. This is the educational response.

When is Abuse Likely to Occur?

Who abuses? Mostly mothers, followed by fathers, boyfriends, relatives, neighbors, babysitters and others. Abuse often occurs when the adult is angry or stressed. Also it can occur when the adult's efforts increase because they see no change in their child's behavior. Inconsistency often leads to abuse. An adult is more likely to abuse or neglect a child if:

- the caretaker was abused as a child
- the caretaker is being abused by a spouse or partner
- the caretaker uses alcohol or other drugs or substances
- the adult expects too much of a child
- the child is the result of an unplanned pregnancy
- the adult is worried about not having enough money
- the adult is having relationship problems with a spouse or partner
- the adult is coping with a family member's illness or death
- the adult is stressed from jobs or other problems (i.e. unemployment, single parenthood)
- the adult is depressed, ill, or has a low frustration tolerance
- the care giver does not have a basic knowledge of normal child behavior/development

Child Factors and social factors typically found in abusive families include, but are not limited to:

- prematurity or neonatal problems (i.e., colic, sleep problems, crying)
- physical handicaps or developmental delay
- chronic or frequent illness
- hyperactivity
- unexpected pregnancy
- multiple births
- bladder and bowel control problems
- temperament of the child or parent (i.e. difficult personality)
- poverty
- limited community resources

What are Some Warning Signs that a Child You Know is Being Abused?

- cuts and bruises in unusual places
- broken bones or internal injuries
- burns
- hard to believe stories about how accidents occurred
- frequent or repeated injuries
- child reporting frequent illness
- dirty hair or skin, frequent diaper rash
- pain, bruising, or bleeding in the genitals

How Can I Prevent Abuse?

As a parent there are a number of ways you can prevent abuse:

- When tension and anger rise, you can take five minutes to cool down and identify the real problem and find the right solution.
- Never strike in anger or frustration.
- Pay attention to stress and learn how to manage that stress.
- Take time for yourself. Arrange time with a friend to watch each other's children when you need a break. Plan ahead.
- Assess your feelings about your interaction with your children. Spend quality time with your children. Tell them that you love them and that they are special. Show them affection by giving them hugs frequently. Frequent positive physical contact helps all children.
- Listen to your children
- Talk to a friend or "buddy"
- Discipline using Time-Out procedures
- Do not use drugs or abuse alcohol
- Call your local mental health help line /hot line (Yellow Pages)
- Take a parenting class at your local school, church, or community agency
- Learn how to discipline effectively — many parents do not know how
- Do not isolate yourself. Reach out early. Remember the harm to your child is significant. Embarrassment is not a good reason to avoid asking for help.

Remember: There are professionals available to help you. ASK! Talk to your school counselor or psychologist or physician for assistance.

Always report suspected abuse: You could be saving that child's life. Federal law and most states require reporting of child abuse by teachers and other professionals.

If you are feeling angry at your child:

- Stop. Take a deep breath and count to 25. Do it again if necessary.
- Remember your child learns by example...*your* example. If you hit, they will hit.
- Put your child in a Time Out chair or safe isolated location (one Time Out minute for each year of age — a four-year-old is placed in Time Out for four (4) minutes).
- Put yourself in Time Out until you cool down.
- Call Parents Anonymous (White Pages of phone book — no names needed).
- Close your eyes and imagine you're hearing what your child is about to hear.
- Take a hot bath or throw cold water in your face.
- Hug a pillow.
- Turn on some favorite music and sing along.
- Write down some helpful words and keep list.

Five "QUICK" Steps:

- **STOP** — what ever is happening
- **STEP AWAY** — Move away from the situation
- **THINK** — for a minute; take some deep breaths and count to 25
- **COMMUNICATE** — I feel_______ (a feeling word), when _____(What makes you feel); because______ (how it affects you). Example: I feel angry when you talk that way to me because it hurts my feelings.
- **SOLVE** — the problem...work it out with the person or seek help from another adult

Community Prevention Strategies: The National Committee to Prevent Child Abuse recommends the following ways to prevent abuse:

- Provide support programs for new parents
- Provide education programs for parents
- Provide early and regular child and family screening and treatment
- Provide improved child care opportunities
- Provide programs for abused children
- Provide life skills training for children and young adults
- Provide family support services
- Provide public information and education

Where Can I Get More Information?

You may find it helpful to contact your school, physician, local health department or mental health center.

Websites for Information:

The following web sites can be accessed to learn more about child abuse and helpful suggestions:

National Committee to Prevent Child Abuse
<http://www.childabuse.org >
or call 1-800-55-NCPCA

The Administration for Children and Families Department of Health and Human Services
<http:// www.acf.dhhs.gov>

Child Abuse and Neglect Clearinghouse
<http://www.calib.com/nccanch>

Books:

These title should be available or readily ordered from your bookstore:

Canter, Lee (1988). *Assertive Discipline for Parents: Revised Edition.* New York: Harper Perennial.

Clark, L. (1996). *SOS for Parents (2nd Edition).* Bowling Green, KY: Parents Press

Eastman, M. and Rozen, S. (1994). *Taming the Dragon in Your Child: Solutions for Breaking the Cycle of Family Anger from Toddler to Teens.* John Wiley & Sons, Inc.

Langston, Teresa A. (1994). *Parenting Without Pressure.* Navpress.

Turecki, (1990). *The Difficult Child.* New York: Bantam Press.

Windell, James (1994). *8 Weeks to a Well-Behaved Child: A Failsafe Program for Toddler Through Teens.* Macmillan Publishing Co.

Wyckoff, J. & Unell, B. (1991). *Discipline Without Shouting or Spanking.* Meadowbrook Press (distributed by Simon and Schuster).

National
Association of
School
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Sexual Abuse of Children and Adolescents

Information for Parents

by Daniel Bromberg
Syracuse University

Background

Child sexual abuse may be defined as "sexual exploitation involving physical contact between a child and another person. Exploitation implies an inequality of power between the child and the abuser on the basis of age, physical size and/or the nature of the emotional relationship. Physical contact includes anal, genital, oral or breast contact." Although legal definitions vary from state to state, when sexual contact between a minor and someone five or more years older occurs, it is likely that the minor is being exploited. In this handout, the terms "child" and "adolescent" will be used interchangeably.

There are good reasons for parents to become knowledgeable about sexual abuse. Sexual abuse is associated with school problems, psychological problems that often continue throughout adult life, and medical problems. Children and adolescents who experience sexual abuse sometimes have difficulty concentrating in school and their grades may drop from previously higher levels. They may also experience depression, general fearfulness, frequent nightmares and other sleep problems, and poor self-esteem. They may exhibit behavior problems both at school and at home. Children and adolescents who have been sexually victimized may have medical symptoms that cannot be explained by a medical problem. This includes frequent headaches and aches and pains in other parts of the body. Moreover, many of these medical complaints continue into the adult years. Clearly, children and adolescents who experience sexual victimization are at risk for developing a variety of serious problems.

Which Adults Abuse? Which Children Become Victims?

Parents often seek ways to protect children from being sexually victimized. They wonder about profiles of "typical" child abusers, presumably so that they can protect children from such individuals. We know that males sexually victimize young people much more often than do females. With this one exception, there is no "typical" adult who seeks sexual contact with children. Statistical evidence strongly suggests that it is older adolescents or adults who are known and trusted by children, rather than complete strangers, who sexually victimize them. It is often trusted individuals such as family friends, babysitters, relatives, youth group leaders and clergymen who persuade children to engage in inappropriate sexual behaviors. Some psychologists believe that it is the violation of the young person's trust that contributes to some of the psychological difficulties associated with sexual abuse.

While there is no "typical" child victim, it is possible to make some statements about risk factors for becoming a victim of sexual abuse. The sexual abuse of girls is reported with much greater frequency than that of boys. In previous years, this led many to conclude that boys are rarely sexually abused. More recent information suggests that boys are abused much more frequently than had previously been thought. However, boys who are victims of sexual crimes are much less likely to report such crimes than are girls.

It has also been suggested that children who are emotionally needy, that is, children whose parents are abusive or neglectful, are victimized more easily than are other children. It is likely that these children are receptive to the attention and affection offered by other adults.

What Are the Signs and Symptoms of Sexual Abuse?

Unfortunately, detecting sexual abuse can be a difficult task. Often, the child victims may be reluctant to disclose the abuse or may deny having been abused. Children may not want the perpetrator to get in trouble, may believe that they themselves will be blamed for "misbehaving," or may have been threatened in some way to prevent disclosure. To further complicate matters, medical examinations often yield findings that are, at best, merely suggestive of sexual abuse. *Any child who reports having sexual contact with a significantly older person should be taken seriously.* Because the manner in which children are questioned can influence their memory for events, detailed questioning is best left to law enforcement officials and appropriately trained medical personnel, psychologists and social workers.

There are a variety of signs and symptoms suggestive of sexual abuse. Unfortunately, there is no one set of reliable diagnostic signs. Detecting sexual abuse often requires attention to clues that may be subtle. You should know that many of these indicators, when taken individually, do not necessarily indicate sexual abuse or any other serious problem. However, you have good reason to be suspicious if *several* indicators are observed. A child's extreme fear or avoidance of going to a particular place or being alone with a particular adult may signal a problem. Changes in appetite, sleep difficulties, having frequent nightmares, bedwetting, crying, and clinging may also be signs that a child is experiencing extreme distress. The distress may be associated with any number of factors, with sexual abuse being one such factor.

Genital problems may also suggest sexual abuse. Vaginal or rectal bleeding, vaginal discharge or infection, swelling of the genitals, complaints about pain in or injury to the genitals, and discomfort when walking or sitting are possible indicators of abuse.

Sometimes, young people who have been abused seem to be preoccupied by sexual matters. Children may engage in sexual behaviors such as: Frequently talking about sex and providing descriptions of sexual behavior that (s)he could not know without direct experience (e.g., reporting that "his thing was long and hard and after I rubbed it, white stuff came out of it"); masturbating in public, particularly if the child has previously been told that masturbation is appropriate only when done in private; touching the sex parts of other children or adults; imitating the act of sexual intercourse; making sexual sounds (sighing, moaning, heavy breathing); asking others to engage in sexual acts with him/her; imitating sexual behavior with dolls or stuffed animals; and showing his/her sex parts to adults.

The long-term effects of abuse are related to many different factors. The child's age at the time, the frequency of abuse, the relationship between the child and abuser, and the support provided to the child after disclosing abuse are all important in the child's recovery from the trauma of abuse.

How Can I Protect My Child From Sexual Abuse?

One of the best ways of preventing sexual abuse from occurring or continuing is by talking with your child frequently and by being generally supportive of your child. In this way, your child is more likely to seek attention from you rather than from another adult. Also, it is important for children to feel that they can talk with you about situations with other adults (e.g., sexual touching) that make them feel uncomfortable. Your child needs to know that you will support him/her if (s)he reports such things to you.

Children can and should be taught specific skills for preventing sexual exploitation before they start spending time away from you. This means that children should be prepared before they begin preschool. This idea may make you uncomfortable. Maybe you just don't know what to say. Maybe you are worried that discussing sexual abuse will frighten your children. You should know that there are ways to teach your children important self-protection skills without frightening them.

You can best prepare your children by teaching them that they have certain rights. You should also teach your children what to do if an older person tries to violate these rights or makes your children feel uncomfortable or confused. Reassure your children that most adults would never harm a child. You should discuss the following points with your children:

- All children and adults have "private parts". These are the parts of the body that are covered by a bathing suit. Adults and older children generally should not touch children's private parts. (Parents, other caregivers, and medical professionals may, at times, have a legitimate need to touch a child's private parts.) A child should *never* be asked to touch an older person's private parts.
- Tell your child that (s)he has the right to say "No!" or "Stop it!" to any older person who tries to touch him/her in a way that makes your child feel uncomfortable, confused, or frightened. Tell your child that you *always* need to be told if this happens.
- If an older child or adult touches a "private part" or touches your child in a way that makes him/her feel uncomfortable, (s)he is to report the incident to you or another trusted adult. You might want to work with your child to come up with a list of trusted adults to tell just in case you can't be reached. School officials and police officers are often good choices.
- It is important *not* to keep secrets that an adult orders you to keep. Adults sometimes show children pornography, give them money or gifts, or alcohol and drugs to lower a child's inhibitions. Often, the adult demands that these things be kept secret. With young children, adults sometimes threaten to hurt or kill the child or the child's parents if the child shares secrets about sexual activities. It may be helpful to inform your child that nobody will hurt you and that you won't ever let anyone hurt your children, either. Anytime an adult orders your child to keep a secret, it is important to share that secret with a parent or other trusted adult. (You may want to explain the difference between a "surprise" and a "secret". A "surprise" is a positive event that is kept private for a short time and then shared. Birthday presents are a good example.)
- Parents or the person in charge need to know where children are at all times. Never leave with someone, even someone you know, or get into a car or go into someone's home unless you get permission from a parent or the person in charge first.

Finally, it is important to role-play situations with your child. You can pretend to be an adult requesting that your child do something inappropriate. Your child should practice things to say and do in these situations. You should then give your child feedback. Give praise for things said and done well. Offer suggestions about other things your child should say and do in that situation. Then, do the same role-play again having your child use your suggestions. You can repeat this process a few times until your child says and does just the right things two or three different times.

Why is it important to do role-plays? Imagine that your child has a part in a school play. You know that your child's performance will be better if he rehearses his lines many times. Going through "dress rehearsals" helps your child because (s)he has practice in saying the right lines and doing the right things on stage. Your child performs his part "automatically" after practicing many, many times. The same thing happens when you role-play situations having to do with your child's personal safety. Your child is better able to say and do just the right things automatically when an adult asks your child to do something inappropriate.

What If My Child Has Been Sexually Abused?

If you are fairly certain: The first thing to do is to take time to calm yourself so that you help your child more effectively. If you are fairly certain that your child has been sexually victimized, it is important that your child be examined by a physician. It is preferable for the examination to be conducted by a pediatrician who has experience with sexually victimized children. If the incident occurred recently, do not allow your child to bathe or change clothes before the medical examination. Fibers and body fluids need to be collected as physical evidence. The medical examination is important so that physical trauma from the incident can be treated. In addition, tests for sexually transmitted diseases (e.g., AIDS) and pregnancy may need to be conducted.

Your child will also need your reassurance that you still love him/her and that you know that what happened was not his/her fault. Your child will almost certainly benefit from counseling or psychotherapy. The psychological issues surrounding sexual abuse are often best addressed by parents *and* mental health professionals working together. Research has shown that children who have been abused suffer less traumatic effects when they are able to maintain a relationship with a caring (non-abusing) adult. Children need to feel that their statements about abuse are believed by significant others; they also need to receive accurate information about abuse and sexuality.

If you suspect, but do not know, that your child has been sexually abused, you should pursue a different course of action. Think about what has made you suspicious and ask your child questions that address your concerns. For example, has anyone shown your child pornography? Has anyone suggested that it might be fun to get undressed and then take pictures? Has anyone touched your child's "private parts" or asked your child to touch theirs? Reassure your child that you will not be angry if any of these things has happened. Let your child know that you need to know if any of these things has happened so that you can help your child and protect him/her from harm.

If your child denies that anything inappropriate has happened, do not keep questioning your child. You might want to take steps to monitor your child's welfare in situations of potential danger. For example, if you are concerned about suspicious activities in your child's day-care setting, you might make some unannounced visits to the day care center.

It is important for parents to help equip their children to resist the inappropriate and illegal behaviors of individuals who have more years of life experience. Parental efforts in this domain are likely to help children and adolescents to protect themselves from sexual victimization.

Resources for Parents

American Academy of Pediatrics. (1990). *Child sexual abuse: What it is and how to prevent it [Pamphlet].* Elk Grove Village, IL: Author.

National Center for Missing & Exploited Children. (1985). *Child protection [Pamphlet].* Arlington, VA: Author.

National Center for Missing & Exploited Children. *Parental guidelines in finding professional help in case your child is missing or the victim of sexual abuse or exploitation [Pamphlet].* Arlington, VA: Author.

Wooden, K. (1994). *Child lures: Family guide for prevention of sexual assault and abduction.* Shelburne, VT: The Wooden Publishing House.

Resources for Parents and Children

Allen, S. & Dlugokinski, E. (1992). *Ben's secret.* Raleigh, NC: Feelings Factory. [A story to be read to children, or by the child alone, regarding disclosure. It reinforces that notion that abuse is not the child's fault and encourages disclosure to trusted adults.]

Wachter, O. (1983). *No more secrets for me.* Boston: Little, Brown & Co. [Through 4 short stories, young children are introduced to scenarios and types of touch that might make them uncomfortable.]

Some material for this handout is adapted from "Child Sexual Abuse" by C. Horton and T.K Cruise, in Children's Needs II: Development, Problems and Alternatives *(1997; National Association of School Psychologists). Thanks to Jill Jenkins, Psy.D., of Bellaterra, Spain, for her review and suggestions for this handout.*

NATIONAL
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Sexual Abuse of Children and Adolescents

A Handout for Teachers

by Daniel Bromberg
Syracuse University

Background

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There are good reasons for teachers to become knowledgeable about sexual abuse. It is estimated that 20% of girls and 5-10% of boys are sexually abused by an adult. Sexual abuse is associated with school problems, psychological problems that often continue throughout adult life, and medical problems. Children and adolescents who experience sexual abuse sometimes have difficulty concentrating in school and their grades may drop from previously higher levels. They may also experience depression, general fearfulness, frequent nightmares and other sleep problems, and poor self-esteem. They may exhibit behavior problems both at school and at home. Children and adolescents who have been sexually victimized may have medical symptoms that cannot be explained by a medical problem. This includes frequent headaches and aches and pains in other parts of the body. Moreover, many of these medical complaints continue into the adult years. Clearly, children and adolescents who experience sexual victimization are at risk for developing a variety of serious problems.

Which Adults Abuse? Which Children Become Victims?

Teachers sometimes seek ways to protect children from being sexually victimized. They wonder about profiles of "typical" child abusers, presumably so that they can protect children from such individuals. We know that males sexually victimize young people much more often than do females. With this one exception, there is no "typical" adult who seeks sexual contact with children. Statistical evidence strongly suggests that it is older adolescents or adults who are known and trusted by children, rather than complete strangers, who sexually victimize them. It is often trusted individuals such as family friends, babysitters, relatives, youth group leaders, teachers and clergymen who persuade children to engage in inappropriate sexual behaviors. Some psychologists believe that it is the violation of the young person's trust that contributes to many of the psychological difficulties associated with sexual abuse.

While there is no "typical" child victim, it is possible to make some statements about risk factors for being sexually victimized. The sexual abuse of girls is reported with much greater frequency than that of boys. In previous years, this led many to conclude that boys are rarely sexually abused. More recent information suggests that boys are abused much more frequently than had previously been thought. However, boys who are victims of sexual crimes are much less likely to report them than are girls.

It has also been suggested that children who are emotionally needy, that is, children whose parents are abusive or neglectful, are victimized more easily than are other children. It is possible that these children are receptive to the attention and affection offered by other adults.

What Are the Signs and Symptoms of Sexual Abuse?

Unfortunately, detecting sexual abuse can be a difficult task. Often, the child victims may be reluctant to disclose the abuse or may deny having been abused. Children may not want the perpetrator to get in trouble, may believe that they themselves will be blamed for "misbehaving," or may have been threatened in some way to prevent disclosure from occurring. To further complicate matters, medical examinations often yield findings that are, at best, merely suggestive of sexual abuse. *Any child who reports having sexual contact with a significantly older person should be taken seriously.* Because the manner in which children are questioned can influence their memory for events, detailed questioning is best left to law enforcement officials, and appropriately trained medical personnel, psychologists and social workers.

There are a variety of signs and symptoms suggestive of sexual abuse. Unfortunately, there is no one set of reliable diagnostic signs. Detecting sexual abuse often requires attention to clues that may be subtle. You should know that many of these indicators, when taken individually, do not necessarily indicate sexual abuse or any other serious problem. However, you have good reason to be suspicious if *several* indicators are observed. A child's extreme fear or avoidance of going to a particular place or being alone with a particular adult may signal a problem. Reported changes in appetite, sleep difficulties, having frequent nightmares, bedwetting, crying and clinging may also be signs that a child is experiencing extreme distress. The distress may be associated with any number of factors, with sexual abuse being one such factor.

Genital problems may also suggest sexual abuse. Vaginal or rectal bleeding, vaginal discharge or infection, swelling of the genitals, complaints about pain in or injury to the genitals, and discomfort when walking or sitting are possible indicators of abuse.

Sometimes, young people who have been abused seem to be preoccupied by sexual matters. Children may engage in sexual behaviors such as: Frequently talking about sex and providing descriptions of sexual behavior that (s)he could not know without direct experience (e.g., reporting that "his thing was long and hard and after I rubbed it, white stuff came out of it"); masturbating in public, particularly if the child has previously been told that masturbation is appropriate only when done in private; touching the sex parts of other children or adults; imitating the act of sexual intercourse; making sexual sounds (sighing, moaning, heavy breathing); asking others to engage in sexual acts with him/her; imitating sexual behavior with dolls or stuffed animals; and showing sex parts to adults.

Developmental effects: In addition to the above general effects of sexual abuse, children at specific developmental levels will display some specific symptoms that are indicative of possible sexual abuse:

Preschool: Young children will feel guilt and shame as well as confusion as a result of sexual abuse. The most distinctive symptom among children age 2-5 years is persistent sexualized talk and play with self, peers or toys. Their talk and actions demonstrate sexual information well beyond what would be expected for young children.

School-age: During the elementary school years, abused children may feel intense shame and guilt and fear disclosing abuse — out of fear of punishment or fear of not being believed. Girls are more likely to withdraw and become depressed, while boys are more likely to act out. When combined with sexualized talk and behavior, these symptoms are more likely indicative of abuse than of other stressors.

Adolescence: Running away, promiscuity and substance abuse are frequent effects of abuse among adolescents. Girls in particular are more likely to be self-destructive and suicidal and often have high levels of depression. Guilt and self-blame often lead to lowered self-esteem.

Mediating effects: The long-term effects of sexual abuse have been studied by researchers yielding inconsistent results. It has been assumed that factors directly related to the abuse itself — age of victim, duration and frequency of abuse, relationship between victim and perpetrator — are predictive of later adjustment. However, newer research suggests that other factors, particularly attribution of blame and response to disclosure, may be equally important in predicting long-term outcomes. It appears that children who receive ongoing support and information about abuse following disclosure, particularly those who maintain a close relationship with a significant (nonabusing) adult, experience less trauma.

Responding to Suspicions of Sexual Abuse

In all 50 states, teachers and other school personnel are mandated reporters of suspected child abuse. This means that you have an ethical and legal obligation to report any reasonable suspicion of child abuse to your local child protective and/or law enforcement agency. Specific laws regarding reporting of suspected child abuse vary from state to state. Policies about reporting vary between school districts within the same state. Because of the great variation in laws and policies about reporting, it is important to become familiar with laws and policies in your locale. Nonetheless, it is possible to offer some general guidelines about reporting suspected child abuse.

One question that teachers often have is how they are to determine when their suspicion is a "reasonable" one. One possible course of action is to make an anonymous telephone call to your local child protective agency. Explain that you are a mandated reporter and that you are not sure if the case is "reportable." Describe the situation to the child protection worker and ask if the situation that you have described is "reportable." Regardless of the answer, ask for the name of the worker with whom you have spoken. Be sure to keep a record of the phone call. Include a description of the situation as you described it to the child protective services worker, the date and time of the phone call, the name of the child protective services worker, the response given and the rationale for the response given by the child protective services worker.

After having determined that your suspicion is "reasonable," it is important to consider the circumstances surrounding the suspected sexual abuse. If the suspected perpetrator is a parent or guardian, then reports must be filed with both child protective and law enforcement agencies. This applies if the perpetrator is someone other than a parent or guardian if the parent or guardian might reasonably have suspected that abuse is occurring and took no actions to protect the child (e.g., cases where the perpetrator is the mother's live-in boyfriend). In most cases where the perpetrator is not a family member or not living in the household, the case needs to be reported to a law enforcement agency only.

Rather than having teachers report their own suspicions of child abuse, many school districts have policies about funneling all reports through one or more individuals in a given school building. In some cases, the "designated reporter" is a school social worker. In other cases, the "designated reporter" may be a school nurse, psychologist or administrator. When giving your report through a "designated reporter" rather than to child protective or law enforcement agencies directly, be sure to keep a record of the report that you made. In many states, the mandated reporter with the reasonable suspicion is ultimately held accountable for making the report.

Teachers sometimes worry about the possible consequences of filing a report of suspected child maltreatment. One concern often centers on being identified as the individual who filed the report. A second concern centers on being held liable if the report is later deemed to be unfounded. In many states, child protective and police agencies will not reveal the identity of the individual reporting. Thus, a parent may be informed that a report was filed through the school, but the specific reporter at the school is usually kept confidential. Many states have provisions for the "good faith" reporting of child maltreatment. Mandated reporters are usually shielded from civil and criminal liability for making reports "in good faith." In many states, "good faith" on the part of mandated reporters is presumed.

Because teachers spend so much time with children, they are in an excellent position to recognize child maltreatment. In cases where a child is being victimized by a relative or another person living in the same household, a report made by a teacher may well lead to a positive change in the child-victim's life.

Supporting Abused Students

Teachers and other school personnel can support the student who is a victim of sexual abuse:

- The student's trauma can be lessened by a supportive and nonjudgmental response to discloure.
- A health recovery environment at home and at school is critical. Remember that the involvement of at least one caring significant adult in the life of the child victim is an essential ingredient for positive outcomes.
- The school psychologist, social worker or counselor can help families locate appropriate therapeutic resources in the community. School-based support groups can also be helpful in addressing the needs of child victims of sexual abuse. Groups can help provide accurate information about abuse and sexuality, and can help address distorted thinking such as self-blaming statements. Such groups can also help students feel less isolated in their experiences and feelings.
- School-based prevention programs not only teach children skills to resist abuse and recognize potential danger, but can also promote disclosure of current and past abuse. Such programs should be very carefully selected with the help of school and community professionals and only implemented by those professionals trained to work with child abuse victims.

Resources for Teachers

Horton, C. & Cruise, T. (1997). Child sexual abuse. In G. Bear, K. Minke & A. Thomas (Eds.), *Children's needs II: Development, problems and alternatives* (pp.719-727). Bethesda, MD: National Association of School Psychologists.

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Some material for this handout is adapted from "Child Sexual Abuse" by C. Horton and T.K Cruise, in Children's Needs II: Development, Problems and Alternatives *(1997; National Association of School Psychologists). Thanks to Jill Jenkins, Psy.D., of Bellaterra, Spain, for her review and suggestions for this handout.*

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Stuttering

Information for Parents and Teachers

by Melissa A. Bray and Thomas K. Kehle
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Background

Stuttering is a speech disorder that is typically characterized by single and multi-syllablic word repetitions, part-word repetitions, sound and syllable prolongations and/or inability to move lips and/ or vocal folds so to produce meaningful sounds. Often these dysfluencies are accompanied by non-speech sounds, facial grimaces, head movements and movements of the arms or legs. Normal speakers say 3% or fewer stuttered syllables; therefore, a diagnosis of stuttering is not applied unless the speaker "stutters" more than this criterion.

Stuttering can be caused by many variables. In the majority of cases, it appears as if there are multiple contributors unique to the individual. Some of these contributors could be genetic transmission, emotional states, cognitive and linguistic processes, learning factors, speech motor deficits and neurological abnormalities.

Development

Neither the parents' rate of speech nor their attempts to provide feedback regarding their child's stuttering are significant in the development of stuttering. Stuttering often begins between ages 2 and 8, and happens gradually as the child begins to speak in sentences. Stuttering is seen in approximately 4% of preschoolers with a ratio of 2:1, male to female. Across the ages, about one percent of the population stutters and there is a ratio of 3:1 male to female. This discrepancy is probably due to the fact that approximately half the children who stutter recover before adulthood without any intervention. Also, females who stutter are more likely than males to recover. Early professional intervention is recommended in that stuttering appears to be more modifiable during the early stages.

There are differences among recovered, persistent, psychogenic and neurogenic stuttering. *Persistent* stutterers, in comparison to those who recover, tend to be male, have a later onset age (i.e., approximately age 3), poorer phonological, language and nonverbal skills, a family history of persistent stuttering, and stuttering for at least 15 months. Fewer children recover once they are school-aged. School-aged persistent stutterers, in comparison to their peers who recover, may exhibit a higher frequency of dysfluencies and possibly a physical component.

The term *psychogenic* stuttering is defined as learned stuttering. *Neurogenic* stuttering refers to stuttering that is the result of brain injury, genetic transmission and neuromotor dysfunction.

What Can I Do as a Parent?

In addition to securing professional intervention, parental involvement also appears to be beneficial in reducing stuttering. The following are recommended strategies for parents:

- For children exhibiting either recovering or normal dysfluencies, parents should simply ignore them, allow the child time to respond, and avoid filling in words and telling the child to slow down.
- For children exhibiting chronic stuttering, parents should model a relatively slower rate of speech, attempt to use age-appropriate language and pause before responding to the child. In addition, it is recommended that parents should avoid interrupting the child's speaking and using negative feedback.

What Can I Do as a Teacher?

Stuttering tends to occur less in oral reading, during choral speaking, or when whispering or singing. Stuttering is exacerbated in anxiety-provoking situations, reading difficult text and in using complex language. Teachers should consider the following:

- Students who stutter should be granted relatively longer periods of time to complete silent reading passages.
- Allow students to become more familiar with written material by having them reread it either silently or orally.
- Because stuttering is inversely related to language skills, instructional techniques (i.e., sentence formulation training) may be beneficial.
- It is also beneficial to use positive reinforcement for stutter-free speech, eliminate or reduce stressful environments, and encourage a slower rate of speech.
- Older children who stutter may profit from using coping skills and increasing their self- efficacy for stutter-free speech.

Resources

Bloodstein, O. (1993). *Stuttering: The search for a cause and cure.* Boston, MA: Allyn and Bacon.

Bloodstein, O. (1995). *A handbook on stuttering* (5th edition). San Diego, CA: Singular Publishing Group, Inc.

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Tourette's Syndrome

Information for Parents and Educators

by Christopher Willis, MS
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Introduction

Tourette's Syndrome (TS) is a chronic constellation of neurobehavioral symptoms and associated features including severe tics. This syndrome, originally described by Gilles de la Tourette in 1857, is a very complex disorder. Family studies often indicate a genetic etiology; however, a specific link to TS has yet to be uncovered. An interaction between environmental influences (e.g., low birth weight or lack of asymmetry in the basal ganglia in the brain) and a genetic predisposition is the most likely determinant for the expression of Tourette's.

TS is a severe type of tic disorder and is relatively uncommon, while milder types of tic disorders are more commonly diagnosed. Researchers estimate the prevalence of TS as between 1:2000 and 1:2500, while transient tics (relatively mild tics that occur for a period of time and disappear) occur in 5-25% of all children at some time. About 1-2% of the school age population experience chronic tics, with TS the most severe and least common. Males are affected by TS much more than females. While TS is not life threatening, there is no known cure. Children and adolescents with Tourette's Syndrome sometimes (not always) require special consideration in school to optimize their learning, behavior control and/or social-emotional development. Accommodations may vary from nothing more than an awareness of the child's condition to more intensive interventions, such as medication, psychotherapy, behavioral management, systems intervention or a combination of approaches.

Characteristics of TS

Diagnostically, TS is defined in terms of involuntary motor and vocal tics which can be classified as simple or complex. Simple motor tics are sudden, brief movements such as eye blinking, facial grimacing or shoulder shrugging. Complex motor tics tend to be slower, more involved behaviors that often appear deliberate in nature, such as touching objects, copropraxia (obscene gesturing) or echokinesis (imitating the movement of others). Simple vocal tics are sudden inarticulate sounds such as throat clearing, barking or grunting. Complex vocal tics, which are often mistaken as purposeful in intent, might include the vocalization of syllables, words or phrases completely out of context. Coprolalia, which is the utterance of obscene or socially inappropriate words, is seen in approximately one in five cases.

The diagnosis of TS generally can not be made until a tic pattern has been established. First tics usually appear at ages 6-8 (and almost always by age 13), and these are usually simple motor tics. Later, vocal and more complex tics emerge, often replacing the earlier motor tics, and become worse at adolescence. The condition is life-long, although the nature of the symptoms can change over time and with treatment.

There is really no "typical" child with Tourette's Syndrome. It is the nature of the disorder to change over time in terms of symptom severity and the anatomic location and frequency of tics. The symptoms and features that a child with TS presents in September may look completely different in June. Additionally, persons with TS are typically able to suppress the expression of tics and symptoms for a short period of time. The symptom picture presented by one child with TS may be different from that of another child with the disorder.

The waxing and waning of symptom severity is a hallmark of Tourette's Syndrome. A person with Tourette's may go for days or weeks with no apparent symptoms, only to have the tics reappear. This feature, along with the involuntary nature of TS, is often misunderstood. Teachers, principals and even parents will point to a period of time when symptoms and associated features were less apparent or less severe, and take it as an indication that the child really can control his behavior. Then when the symptoms inevitable flare up again, the child is unfairly regarded as willfully misbehaving. Misunderstanding can be the most debilitating feature of Tourette's Syndrome.

Associated features: In addition to the tics, there are several features that may be associated with Tourette's Syndrome. Features that can affect a child's school performance and social-emotional development include symptoms of obsessive compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD), learning disabilities (LD), neuropsychological anomalies, school adjustment problems and conduct or behavior disorders. Similar to tics, these features tend to be involuntary and variable in the degree to which they are expressed.

Tourette's Syndrome does not affect a child's intellectual development. Learning problems in terms of processing, impaired visual-motor abilities and fine motor skills have been associated with TS. The impulsiveness and distractibility of ADHD can interfere with a child's ability to maintain his attention *and* his behavior in school. The learning needs of children with TS are serviced along the entire continuum of educational interventions from indirect consultative services to more restrictive special education placements.

Stress and anxiety can exacerbate TS symptoms and associated features. Transition and change (including the anticipation of change) are generally quite problematic for a child with TS. Children with TS are also susceptible to emotional stressors commonly associated with other chronic conditions like diabetes or hemophilia (e.g. denial, social isolation, depression, 'why me?').

Developmental Issues

It is not uncommon to see social skills deficits and delays in emotional development in children with TS. Children do not automatically internalize a value system that tells them if they are "good' children or "bad" children. They compare themselves to their peers and gauge their self esteem on how others, especially adults, respond to them. A child with TS does not automatically understand that the noises he makes, or the "evening-up" rituals she has to *do,* or the distracting twitch in his cheek, or his aggressive behavior are the effect of some neurological anomaly. What the child knows is these behavioral quirks sometimes get him into trouble, make him feel different from the other children, and disrupt his school work. If these assaults on the child's self esteem are not dealt with in a developmentally appropriate manner, the results may include a dangerously low sense of self worth, social isolation, or depression.

Treatment Issues

Generally, treatment of TS involves directly treating the tic symptoms and treating accompanying problems. Mild tics are generally not treated with medication, but medication might be used to treat the accompanying difficulties such as mood difficulties (depression, anxiety), obsessive behaviors, attention deficits, etc. Some medications for one type of problem (such as the use of Ritalin for ADHD) will increase the TS symptoms (tics), making medical management complicated. Some children with TS will need two or medications to address the complexity of symptoms. Good medical monitoring of the effects of medication is supported by close communication with the family and school.

Behavior interventions are often used in combination with medication to help children with TS control their symptoms. Token economies, relaxation training, anger-coping training and social skills training can all be helpful in giving the child with TS more control over his or her symptoms and learning to compensate effectively. Teachers and parents can also be taught to provide support, cues and reinforcement to children with TS, and to help peers and siblings better understand the disorder and how they can help the child with TS.

What Can I Do as a Parent?

Learn as much as you can about TS: As a parent you are the primary advocate for your children. Advocacy for a child with Tourette's Syndrome begins with understanding, which is gained by learning as much as possible about the disorder. Talk with other parents of children with TS (contact the local chapter of the Tourette's Syndrome Association). Become the expert in your child's particular case of TS. Be aware of how your child's tics and associated features are manifested. Does Tourette's effect his/her learning or behavior in school? If so, how? Know the expected effects (and side) of prescribed medications. Anticipate stressful times for your child which may be associated with a change in symptom severity (e.g., the beginning or end of the school year, Little League try-outs, social or family events).

Establish consistent behavioral expectations: Discipline with a child with TS can be difficult to maintain. Nevertheless, responsibility and consequences for behavior are "real world' concepts that children with TS need to learn, notwithstanding their condition. Establish firm but flexible behavioral expectations, tempered by a compassionate appreciation for the effects of TS. Don't allow TS symptoms to be used as an excuse or manipulation.

Work with school personnel: As the primary advocate for your child, establish alliances with personnel at your child's school. Meet with your child's teacher before the first day of every school year. him/her with general information about TS, describe the previous efforts of other teachers, and tell about your child as an individual with TS. The school psychologist is a great resource to facilitate such a meeting.

What Can I Do as a Teacher?

Increase awareness of TS: Educational interventions begin with an awareness of Tourette's Syndrome and its associated features (such awareness is frequently the only intervention necessary). Pamphlets and videos provided by the Tourette's Syndrome Association are a good place to start, however the most valuable resources are often the child's parents and previous teachers, and (especially with adolescents) the child himself. Such an awareness will enable the teacher to respond to a child's involuntary expression of tics with understanding and support, a response which becomes a model for the other children in the class as well as the child with TS.

Be sensitive to conditions that impact tics: Teachers need to be alert to conditions that might disrupt a child's ability to attend to his/her schoolwork. While children with TS may be able to suppress their tics for a period of time, it takes a great deal of concentration to do so, which can detract from their attention to school work. Allowing the child to take a brief respite time out of the classroom to privately release tic urges is a recommended practice in some cases. It is also sometimes helpful to give the child advanced preparation for any out-of-the-ordinary transitions (e.g. field trips) to relieve stress he or she may experience related change.

Make academic accommodations: While teachers should not be afraid to academically challenge a child with TS, occasionally it is necessary to make certain accommodations. Sometimes a child with TS might need to take a test privately and/or orally. if the child has problems with writing, the use of a computer or tape recorder may be a more effective means of expression. Shortened written assignments may also be appropriate.

Consult with support personnel: School psychologists, social workers, counselors, school nurses and other support personnel play many roles in the education of a child with Tourette's Syndrome, such as advocate, consultant, evaluator, counselor and liaison between home and school and school and community providers. Providing emotional support, enhancing self-esteem and academic competence are as important as suppressing tics and other symptoms.

Resources

The Tourette's Syndrome Association, Inc., 42-40 Bell Blvd., Bayside, New York, 11361; (718) 224-2999.

Cohen, D.J., Bruun, R.D., & Leckman, J.F. (Eds.) (1988). *Tourette's Syndrome and tic disorders: Clinical understanding and treatment.* John Wiley and Sons.

Haerle, T. (Ed.).(1992). *Children with Tourette's Syndrome: A parents' guide.* Rockville, MD: Woodbine House.

Kurlan, R. (Eds.). (1993). *Handbook of Tourette's Syndrome and related tic and behavioral disorders.* New York: Marcel Dekker.

Power, T. & Mercugliano, M. (1997). Tic disorders. In G. Bear, K. Minke & A. Thomas (Eds.), *Children's needs II: Development, problems and alternatives* (pp.887-896). Bethesda, MD: National Association of School Psychologists.

Walter, A.L., & Carter, A.S. (1997). Gilles de la Tourette's Syndrome in childhood: A guide for school professionals. *School Psychology Review*, 26, 28-46.

Internet Resources

The (original, but not official) Tourette Syndrome Home Page: *<http://www~ personal.umd.umich.edu/~infinit/tourette.html>*

<http://vh.org/Patients/IHB/Psych/Tourette/TouretteSyndrome.html>

<http://www.stayhealthy.com/hrd/dicopr_heneco_tosy.htm>

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Traumatic Brain Injury (TBI)

A Handout for Parents

by Robert Diamond
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Background

Head injury (also known as Traumatic Brain Injury or TBI) is not rare. Each year as many as 4 out of 100 individuals may have a physical blow or an acceleration/ deceleration (rapid moving and sudden stopping) injury to the head severe enough to be classified as a head injury. Generally, the minimal requirements for this classification are evidence of momentary loss of consciousness, some amnesia surrounding the event, or confusion and disorientation following the event. Head injury is more common in children than adults, and more common in males than females. Head injuries are classified as open (if there is skull fracture) or closed (with no skull fracture); and on a continuum from mild to moderate to severe. The severity ratings are not universally consistent, but generally mild injuries do not involve prolonged loss of consciousness or medical complications requiring extended hospitalization (more than an overnight stay). Closed head injuries are more common than open head injuries. Mild head injuries are more common than moderate head injuries, which are more common than severe head injuries.

Typical causes of head injury include motor vehicle accidents, athletic injuries, falls and physical assault. Even a common activity such as bicycle riding can cause thousands of head injuries each year (especially when riders do not wear helmets). The most frequent result of head injury is a disruption of intellectual abilities. However, other consequences may include personality changes, impulse control problems, headaches and seizures. An encouraging fact about the intellectual and behavioral after-effects of head injury is that in the majority of cases, there is substantial improvement over time.

Development

Children with moderate head injury generally will have extended hospitalizations with rehabilitation; those with severe head injuries will invariably have these services. Children with mild head injury generally do not need these services. Unfortunately, some children with mild head injury (most research indicates less than a third) will experience at least some persistent difficulties.

For most children, there is rapid recovery of a substantial portion of pre-injury abilities during the first few months after injury. More moderate gains may continue for up to two years. Verbal language abilities and well learned material recover rapidly, while the recovery of reasoning and new learning abilities may take much longer. The early recovery of language abilities may leave head injured children in the difficult position of seeming more capable and recovered than they actually are.

The course of head injury in children is complicated by the fact that the human brain continues to develop and mature during the first two decades of life. While in adults the alternatives following head injury are improvement or persistence of deficits; in children a third pattern is possible. Symptoms may emerge months or years after the head injury at the time when damaged but previously inactive brain systems are developmentally slated to mature.

Physical, psychological and environmental factors are involved in the recovery from head injury. For more severe head injuries, physical factors are generally most significant, but for mild head injuries, psychological and environmental factors can be vital. One point of concern is that mild head injured individuals may become locked into deficits by experiencing difficulties with a premature return to pre-injury activity levels. A gradual and cautious return to educational and extracurricular activities as they are tolerated is indicated.

The consequences of mild head injury are often subtle and not easily documented without specialized assessment. It is also often difficult for families and for those who work with children to connect learning problems to a mild head injury that occurred months or even years previously. In this situation, a child may be perceived as unmotivated, lazy, negative or lacking in ability. These mistaken perceptions will only compound difficulties and interfere with recovery or adaptation to persistent difficulties.

Treatment

In addition to immediate medical treatment of the injury itself and subsequent hospitalization, children with head injuries may require short or long-term physical therapy, occupational therapy and/or speech therapy. These therapies can be provided while your child is hospitalized and later, as an "outpatient" or through the school's special education department. Depending on the severity and consequences of the injury, your child might also need special education services at school to help overcome behavioral and academic difficulties resulting from the injury. Some children will require an Individual Educational Plan (IEP) that outlines the special education services; some chldren will only require modifications in their school program that can be outlined in a Section 504 Plan. School personnel and parent advocate organizations can help explain these services and your child's rights to services.

Some children benefit from medication following a head injury to control seizures, to help focus attention, to reduce anxiety and to regulate mood. Medication to address behavioral and emotional issues is best used in combination with behavior management strategies and/or counseling, either through the school or through a community agency. Families may also benefit from family counseling and/or support groups.

What Can I Do as a Parent?

An ounce of prevention is worth a pound of cure. It is better to prevent a head injury than to deal with the consequences of one. Use seat belts and child safety seats in automobiles. If your children are engaging in high-risk activities (bicycling, horseback riding, riding all-terrain vehicles, participating in contact sports, etc.), require them to wear protective headgear.

Better safe than sorry. Seek medical attention if your child has had even a momentary loss of consciousness or period of unresponsiveness. Other indicators of the need for a medical check include confusion, grogginess, visual problems, difficulty remembering what happened immediately before or after the injury, a severe headache which develops a few hours after the injury, vomiting, uneven pupil size, or limb weakness on one side. If you aren't sure whether or not you should see a physician, *see a physician.*

Don't compare apples and organes. Recognize that medical professionals are primarily concerned with physical health. Following a minor head injury, your child may clearly not be at medical risk. Your physician's reassurance that there has been a complete recovery is medically accurate. However, subtle cognitive difficulties may continue for an extended period. A comprehensive psychological evaluation of your child may be necessary to identify deficits and to direct any intervention. Your school psychologist may either perform this evaluation or be able to refer you to a clinical neuropsychologist.

Don't keep the schools in the dark. If your child has had a head injury severe enough to require extended hospitalization and a rehabilitation program, be sure that the program coordinates efforts with your child's school. The types of intellectual deficits seen following mild head injury in children are often first noticed in the school setting. If teachers and other school personnel are not aware that your child has had a head injury, their expectations may not be consistent with your child's capabilities. This discrepancy may lead to the type of stress and negative conditions that can prolong difficulties. Once they are aware of your child's injury and course of recovery, school personnel will also be able to work with you to help manage any behavioral or academic difficulties your child is experiencing. Your child might benefit from some behavior interventions to help focus attention, reduce frustration and encourage positive interactions with classmates. Academic support such as teaching your child specific strategies to remember and organize information may also be helpful.

Let nature take its course. The most important function of the family, the school and others in the environment of a child with mild head injury is to allow the natural recovery process to occur. Everyone involved with your child should understand that there may be some decline in intellectual efficiency but that improvement is expected. The degree of improvement is difficult to predict, and may range from a complete recovery to a persistent loss of certain abilities. It will be best to maintain an attitude of realistic optimism.

Resources

For medical questions or concerns about physical symptoms:

- The emergency room or trauma center at your local hospital
- Your child's physician
- If your child is hospitalized, the nursing and professional staff of the hospital unit

For questions about recovery and possible effects of head injury:

- If your child is hospitalized, the neuropsychology, education, physical therapy, speech therapy and occupational therapy staffs
- Instructional and support staff at your child's school, particularly the school psychologist or special education resource teacher.
- Brain Injury Association, Inc.: 18A Vernon Street, Framingham, MA 01701; (800)444-6443.

Print Resources

Mira, M.P., Tucker, B.F. & Tyler, J.S. (1992). Traumatic brain injury in children and adolescents: A sourcebook for teachers and other school personnel. Austin, TX: Pro-Ed.

Savage, R.C. & Wolcott, G.F. (1994). Educational dimensions of acquired brain injury. Austin, TX: Pro-Ed.

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Traumatic Brain Injury (TBI)

A Handout for Teachers

by Rik D'Amato, Ph.D., University of Northern Colorado
Elaine Clark, Ph.D., University of Utah and
Robert Diamond, Ph.D., University of Virginia Health Sciences Center

Background

Each year as many as 4 out of 100 individuals may have a physical blow or an acceleration/deceleration (rapid moving and sudden stopping) injury to the head severe enough to be classified as a Traumatic Brain Injury (TBI). Generally, the minimal requirements for this classification are evidence of momentary loss of consciousness, some amnesia surrounding the event, or confusion and disorientation following the event. Head injury is more common in children than adults, and more common in males than females. Head injuries are classified as open (if there is skull fracture) or closed (with no skull fracture) and on a continuum from mild to moderate to severe. The severity ratings are not universally consistent, but generally mild injuries do not involve prolonged loss of consciousness or medical complications requiring extended hospitalization (more than an overnight stay). Closed head injuries are more common than open head injuries. Mild head injuries are more common than moderate head injuries, which are more common than severe head injuries.

Typical causes of head injury include motor vehicle accidents, athletic injuries, falls and physical assault. Even a common activity such as bicycle riding can cause thousands of head injuries each year (especially when riders do not wear helmets). The most frequent result of head injury is a disruption of intellectual abilities. However, other consequences may include personality changes, impulse control problems, headaches and seizures. An encouraging fact about the intellectual and behavioral after-effects of head injury is that in the majority of cases, there is substantial improvement over time. However, approximately 20-40% of children and adolescents who sustain a Traumatic Brain Injury will have some degree of persistent impairment.

Teachers have been teaching students with TBI throughout their careers. Many, however, lack information concerning the unique characteristics of these children and do not realize what they can do to facilitate their learning. Schools are an important extension of the recovery process that begins during hospitalization. Surprisingly few children receive any follow-care once they are discharged, even those with serious injuries. For many, recovery takes months, even years; for some, recovery is never complete and impairments are permanent. This is particularly true among those who sustain *severe* brain injuries, a TBI group that is growing in number due to the relatively recent improvements in life-saving techniques, patient transport and medical technology. Although it is not always easy to predict who will have what problems, and for how long, as a general rule, the more serious the injury, the more significant and persistent the problems. For the majority, the problems are new; for all survivors, the onset of problems is sudden and the adjustment difficult. This handout is intended to help teachers understand what they can do to ease the adjustment process and increase students' chances of success both in and outside the classroom.

Problems and Treatment of TBI Students

Recovery and persistent problems: For most children, there is rapid recovery of a substantial portion of pre-injury abilities during the first few months after injury. More moderate gains may continue for up to two years. Verbal language abilities and well-learned material recover rapidly, while the recovery of reasoning and new learning abilities may take much longer.

Students with persistent impairments display a very broad range of problems, although certain difficulties are more common than others. For example, headaches and sensory deficits frequently occur. Nearly half of those with more serious injuries have difficulties with vision or hearing, and about one-quarter have headaches. Although difficult to observe, these problems potentially interfere with learning. The early recovery of language and motor abilities (gait, coordination, speech) may prompt unrealistic expectations that other functions will recover as rapidly and completely, and that the student is "back to normal." Thus it is not surprising that achievement and other problems often go unnoticed.

Subtle language problems (e.g., verbal comprehension, word finding and concept formation) and cognitive difficulties (attention, memory, organization and problem solving) can interfere with academic performance. By the time these problems become apparent, however, the student has experienced increasing frustration that in some cases has turned into anger and depression. Whereas some personality changes may be a direct result of the brain injury, some are likely to be an indirect result of trying to adjust to problems without sufficient help.

Treatment: Children with head injuries may require short or long-term physical therapy, occupational therapy and/or speech therapy. These therapies can be provided while the student is still hospitalized and, later, as an "outpatient" or through the school's special education department. Depending on the severity and consequences of the injury, a TBI student might need special education services at school to help overcome behavioral and academic difficulties resulting from the injury. Some children will require an Individual Educational Plan (IEP) that outlines the special education services; some children will only require modifications in their school program that can be outlined in a Section 504 Plan.

Some children benefit from medication following a head injury to control seizures, to help focus attention, to reduce anxiety and to regulate mood. Medication to address behavioral and emotional issues is best used in combination with behavior management strategies and/or counseling, either through the school or through a community agency. Families may also benefit from family counseling and/or support groups.

What Can Teachers Do? The "SOS" Model

D'Amato and Rothlisberg (1996) have advocated that teachers evaluate and intervene in the areas of *Structure, Organization* and *Strategies (SOS)*:

Structure

Educators should structure environments to orient students and remove frustrations. Minimal distractions, clear expectations for the student, and a basic routine will promote growth.

- **Increase teacher consistency:** Changes are difficult for students with TBI. Thus, they should be placed in classrooms that have been carefully selected, that have a low student-teacher ratio and where, ideally, teachers can have the same student for multiple years. For example, the student could have the same teacher for third and fourth grade. Ancillary staff should also remain as consistent as possible.
- **Augment behavioral consistency:** Some argue that behavioral consistency is the most important characteristic of the TBI student's classroom. Students should have brief and clear rules that are understandable, reasonable and obtainable, with consequences enforced across the educational experience.
- **Control environmental stimulation:** Stimulation must be controlled in all areas of the school. Consider using study carrels, headphones, ear plugs and special learning areas that can provide the reduced or enriched stimulation needed for success.
- **Consider endurance and stamina:** Since TBI students may tire easily, the length of the school day may need to be modified or increased test time provided. Lengthy homework assignments or long cooperative learning activities may also need modification.

- **Utilize a life skills curriculum:** An evaluation of the degree of brain damage should help determine the type of curriculum offered. Students with significant impairment should receive a curriculum based on activities relevant to everyday living (e.g., self care, using the telephone, reading survival words, balancing a check book, using public transportation, etc.).
- **Support and validate feelings:** Students who have experienced a brain injury need to be encouraged; teachers need to focus on what these students are able to accomplish. Counseling and support groups should be available.
- **Forge a home-school partnership:** While education for all children should have a strong link to home, this is critical for students with TBI. Home-school communication should address activities that the student is to complete at home, information about school progress, and strategies to assure consistent behavioral programming between home and school. Preventative activities can be undertaken to head off problems before they exacerbate the student's difficulties.
- **Offer staff training and inservices:** Serving students with TBI in the schools is a relatively recent phenomena. Schools should consider offering staff training to teach all professionals how to accommodate the needs of this unique population. Many excellent programs are available for school personnel (see Clark and Hostetter, 1995).

Organization

Organization refers to the necessary environmental cues and aids to help students learn.

- **Utilize tactics of effective instruction:** Students must plan in advance to learn and educators must help by providing advance organizers, multimodal cues and attention-focusing activities (such as selecting the main idea). Students need to learn "how to get ready" to learn.
- **Organize assignments:** Students will need help in learning how to organize assignments, notebooks and supplies, including what assignments need to be completed first. The typical workload may need to be reduced and the use of note-takers and tape recorders considered.

Strategies

In addition to considering organization and structure, unique approaches to teaching should be considered. Strategy instruction involves attempts to help students elect problem-solving methods and tactics to make learning more efficient.

- **Consider method or process:** Educators typically focus on what is to be taught and not *how* the material should be taught. For students with TBI, learning styles (use of phonetic approaches, simultaneous approaches and modalities) should be considered.
- **Utilize compensatory methods:** Students with cerebral damage may have serious impairment that precludes learning of certain skills. For example, if it is clear that a student cannot do mental math calculations, he/she might need to learn to use a calculator.
- **Offer remediation when appropriate:** Students with TBI often miss a great deal of school. These students may, therefore, benefit from direct instruction in content areas.
- **Provide role models:** Since we learn by what we see and with whom we interact, it is important to allow students with TBI to work with peers who display appropriate behaviors.
- **Teach social skills:** Many students with TBI have lost friends and are in need of social skills training. The classroom is an idea setting where teachers can work with the entire class on the development of appropriate social skills, and where new friendships can be formed.

Reference

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Resources

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Organization

The Brain Injury Association (800)444-6443

National
Association of
School
Psychologists

Visual Impairments

A Handout for Teachers

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Overview

Although students with visual impairments or total blindness commonly attended residential schools for the blind in the past, similar students are presently more likely to attend public schools in their local communities. However, because visual impairment is a low incidence disability, few teachers have actually had the opportunity to interact with children who have limited vision or to become acquainted with the unique needs and attributes of this heterogeneous population. Only about one school-age pupil in 10,000 has a moderate to severe visual impairment that requires some type of educational remediation or modification so that the pupil can participate in the regular school program, and approximately one in 500 have a mild visual impairment that usually can be remediated through corrective lenses. When a student with a visual impairment is placed in a regular classroom, a consultant with expertise in working with such students generally coordinates the specialized instruction and adaptive equipment needs of the child. This handout is directed toward classroom teachers, and is intended as an overview of considerations for working with students with visual impairments.

General Issues in Schooling

The diversity among students with visual impairments is so great that it is really inaccurate to believe these children really constitute a single "group" at all. Factors which contribute to differences among visually impaired students include: age of onset of vision loss, degree of remaining vision, specific eye condition or disease, and visual efficiency. Each of these factors affects how individual students with visual impairments learn, and must be considered when developing educational programs for them.

Age of Onset: The way in which a child learns is influenced by whether his or her impairment is congenital or acquired after visual learning has begun. A child is considered to have a congenital visual impairment if significant vision was absent or lost at or before birth. In addition, a child who lost vision prior to age five may also be considered as having a congenital visual impairment because little visual imagery is retained. Congenital vision loss may have an impact on the quality of a child's development and learning because of the limitation in the range and variety of available experience, in the ability to get around, and in the control of the environment and self in relation to the environment. Conversely, children who have experienced the world visually, and who have acquired visual memories, are able to retain and build on visual concepts such as space and distance — even after the onset of visual impairment. A majority of school-age children who are visually impaired have congenital impairments.

Degree of Remaining Vision: The degree of residual vision possessed by a child influences the manner in which that child learns about and experiences the world. It also affects the type and amount of modification necessary to teach the child. While some children with visual impairments have only light perception or are totally blind, approximately 80% have some usable vision. A child is classified as "legally blind" if his or her distance vision is measured to be 20/200 or less in the better eye with best correction, or has a visual field no greater than 20 degrees. (Roughly, 20/200 vision means that one can see at a distance of 20 feet what a person with "normal" vision could see at 200 feet, while a visual field of 20 degrees can be likened to "tunnel vision" — a small spot of vision is retained, but the vision surrounding it is missing.) The definition of legal blindness was originally created to determine people's eligibility for public assistance. Educationally, a student is generally eligible for special education support services if his or her measured visual acuity is 20/70 or less in the better eye with corrective lenses.

Specific Eye Disease or Condition: Some children have vision conditions that primarily affect their central vision, making it difficult to complete near work such as reading, but interfering little with their mobility. Conversely, a child with a peripheral field loss may be able to read relatively small print, but have trouble in moving around in the school. Depending on the type of visual problem, one child's vision may fluctuate from day to day while another child's vision remains constant. Also, some children have progressive eye diseases and will experience increasing vision loss over time, while the vision of other children will be stable. Some children need additional illumination to effectively complete visual tasks; others are light sensitive and perform better with low levels of filtered lighting. All of these variables are important considerations when teaching a child with a visual impairment. For this reason, educational consultants often request complete ophthalmological information, as well as a functional low vision assessment report for the child. (A functional vision assessment report describes how the child best uses his or her vision for daily living, and recommends optical and nonoptical low vision aids that will help the child to maximize visual efficiency. Such evaluations are often conducted in conjunction with optometric clinics that specialize in providing low vision services.)

Visual Efficiency: Two students may have the same reported visual acuity, but may function very differently. How well a child uses his/her remaining vision is affected by such factors as prior experience with visual tasks, motivation to use residual vision, visual stamina, and how well the child utilizes low vision aids.

Working with a Child Who Has a Visual Impairment

Before working with a child with visual impairment, teachers need some information about the child's impairment, school history and special needs. Consult with the vision impairment specialist serving the school, previous teachers, the school nurse, parent and (with permission) health service providers who have worked with and evaluated the student. Information such as the following will help teachers make appropriate adaptations in the classroom to help ensure success for the student with vision impairments:

- How much can the student see? (size, contrast, fine detail, color)
- Does this child use Braille?
- How much work can I expect this student to accomplish?
- What are this child's independent functioning skills?
- Will I need a teacher aide to help with this student?
- How does the student feel about the vision loss?
- Are there any special techniques that I can use?
- How do I discipline this student?
- What are this child's abilities?
- What do I tell the other children in the class?

Teaching strategies

- *Buddy system:* Try to utilize a Buddy system when possible. Copying from the board, reading small print and collaborating in labs are examples of ways buddies can be very useful. You may also find opportunities for the student with visual impairment to provide assistance to other students in the school in areas of his/her strength.
- *Verbalize while you teach:* Students with visual impairments miss most visual cues and many written instructions. The teacher should consider talking through classroom activities, for example, describing non-verbal messages and responses, introducing beginnings, transitions, closures to all activities, announcing assignments, and naming speakers.

- *Utilize real-life meaningful examples:* Such examples and concrete material may assist in forming relationships between abstract learning and the child's experience. Consider the use of "hands-on" material where possible, to provide opportunities for kinesthetic and tactile learning.
- *More time? Shorter assignments?* A vision loss results in students taking longer to complete assignments than their classmates. To demonstrate their grasp of the topic they may need longer working time or less written work on tests. You may wish to consider verbal tests or the use of a reader or a scribe in some circumstances.

Adaptive Materials and Devices

Some students with visual impairments will need few adaptive materials; others will benefit from a combination of several adaptive devices. Adaptive equipment for these students will be provided by an educational and/or eyecare specialist. A list of some types of equipment that may be of help to students with limited vision follows. This list is adapted from the pamphlet, *When you have a visually handicapped child in your classroom: suggestions for teachers* (see resources below).

Visual Aids

- **Bookstands** — These help to reduce postural fatigue by bringing the work closer to the reader's eyes.
- **Felt tip pens** — Usually preferred in black, and available in varying widths, these produce a bold letter or diagram which is more easily seen.
- **Acetate** — Usually preferred in yellow, acetate placed over the printed page will tend to darken the print itself as well as heighten the contrast of the background paper.
- **Lamps with rheostats** — With variable intensities and positioning, lamps can provide the additional or dimmed illumination that a visually impaired student may require.
- **Bold-line paper** — For children who find it difficult to see the lines on regular writing paper, paper with darker, thicker lines is available.
- **Page markers** (also called reading windows or typoscopes) — These may be helpful to a child who finds it difficult to focus on a word or line of print.
- **Large-type books** — For comfort or for those children who cannot read regular print at close distance even with an optical aid, large-type is helpful. Its quality or typeface is an important to legibility as its size. Spacing between the letters and lines is also important.
- **Sun visors and other shields** — Children with light sensitivity may need to block out some of the light and glare in the environment.

Auditory Aids

- **Cassette tape recorders** — Children use the recorder to take notes, listen to recorded texts, or formulate compositions or writing assignments.
- **Talking Book Program** — The Library of Congress provides free library services to visually impaired persons, offering a wide variety of books on cassettes. Because the speed at which these cassettes are played differ from the speeds of commercially manufactured recordings, the Library of Congress lends special Talking Book cassette machines to its patrons.
- **Recordings for the Blind** — This agency houses a vast array of school textbooks on tape for student usage.

Electronic Devices

- **Closed Circuit Television (CCTV)** — The CCTV electronically enlarges printed material onto a television screen and can change polarity (i.e. black print on a white background may also be viewed as white print on a black background). The amount of magnification, as well as the contrast and illumination of the electronic image can also be altered.
- **Talking Calculator** — This hand-held calculator speaks each entry and result, and are commercially available at modest prices.

- **Computers with voice-synthesis or large print adaptive software programs** — These programs facilitate computer usage by visually impaired students through synthesized speech or enlargement of the print characters on the monitor.

Through recent advancements in technology, other electronic devices which utilize large print, braille, synthesized speech, or a combination of these means of output are also available.

Optical Aids

- **Glasses with special prescriptions** — Bifocals, prisms, contact lenses, or other lens combinations may be prescribed for a child with visual limitations to use at all time or for specified tasks. Tinted lenses are available for students who are especially light sensitive.
- **Magnifiers** — Either hand-held or in spectacles, magnifiers increase the size of the image reaching the eye.
- **Telescopic aids** — Children use these small telescopes (hand-held or placed in spectacle frames) to view the chalkboard, class demonstrations as well as for mobility purposes.

It is important to note that while specialized techniques and adaptive equipment will facilitate the educational process, the classroom teacher's existing talent, creativity and common sense are equally critical in insuring the educational success of a visually impaired student. Ultimately, it is the collaborative planning/instruction by the classroom teacher and special education consultant that will result in increased skills, self-confidence and independence of the student with a visual impairment.

Resources

Agencies

American Foundation for the Blind, Inc., 15 West 16th Street, New York, NY 10011; (800)232-5463.
American Printing House for the Blind, Inc., 839 Frankfort Avenue, Louisville, KY 40206; (800)223-1839.
Blind Children's Center, 4120 Marathon St, Los Angeles, CA 90020; (800)222-3566.
Council for Exceptional Children, Division for the Visually Impaired, 1920 Association Drive, Reston, VA 22091; (703)620-3660.
National Federation for the Blind, 1800 Johnson St., Baltimore, MD 21230; (410)659-9314.
National Association for Parents of the Visually impaired (NAPVI), PO Box 180806, Austin, TX 78718; (512)459-6651

Print Resources

Blind Children's Center (1993). *First steps: A handbook for teaching young children who are visually impaired.* Los Angeles: Author. (See address above)

Bradley-Johnson, S. (1994). *Psycho-educational assessment of children who are visually impaired or blind: Infancy through high school (2nd edition*). Austin, TX: PRO-ED.

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Corn, A. & Martinez, I. (1986). *When you have a visually handicapped child in your classroom: Suggestions for teachers.* New York: American Foundation for the Blind.

Pogrund, R, Fazzi, D., & Lampert, J. (1992). *Early focus: Working with young blind and visually impaired children and their families.* New York: American Foundation for the Blind.

Scholl, G. T. (1985). Visual impairment. In G. T. Scholl, (Ed.), *The school psychologist and the exceptional child.* (pp. 203-218). Reston, VA: The Council for Exceptional Children.

See also: *Journal of Visual Impairment and Blindness*

NATIONAL
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NASP Position Statements

The National Association of School Psychologists periodically adopts Position Statements and Resolutions on specific issues related to education and child mental health/welfare. These statements reflect "official" organization policy and must go through a rigorous review prior to adoption by the NASP Delegate Assembly. At this time (April, 1998), a number of NASP Position Statetments and Resolutions are undergoing review and revision. Included in this section are two recently adopted statements. Over the next year, many older statements will be revised and reconsidered for adoption. New and revised Position Statements are published in the NASP *Communiqué*; you may wish to photocopy these statements and add to this section for easy reference.

NATIONAL
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Position Statement on School Violence

Children and youth are the victims of more crimes than any other age group in the United States today. Violence against children in any setting is disturbing; when it occurs at school, it is especially destructive, and swift action must be taken to ensure the safety of all students and the staff who care for them. The National Association of School Psychologists resolves to help rid America's schools of the destructive influences of violence in all its forms. This can be accomplished through prevention programs, through direct assistance to victims of school violence, through efforts to reduce the incidence of future violence by perpetrators, and through joining other community groups to sponsor anti-violence initiatives.

Violence in schools violates fundamental assumptions that society holds about the role of schooling in the lives of children and youth. When parents leave their sons and daughters at the schoolhouse door each day, they trust that their children will be cared for and safe. When violence occurs at school, this trust is broken in profound and permanent ways. For this reason, NASP believes that schools are rightfully held to a stricter standard than are other segments of society.

School violence threatens the physical, psychological, or emotional well-being of students and school staff. These threats may occur on school grounds or at school-sponsored activities, and they include but are not limited to physical assaults with and without weapons, bullying, and social isolation. To reduce school violence, schools must ensure that no harm comes to anyone on school campuses at any time. To achieve this goal, efforts must be made to reduce obvious aggressive and illegal behaviors as well as other behaviors that, while not illegal, may damage a student's development and negatively affect school climate.

Creating Safe Schools

Schools must maintain campuses that are safe and conducive to learning. NASP believes that efforts to create safe schools can take many forms. Essential actions include but are not limited to intervening with aggressive students, implementing victim support programs, establishing school-wide violence prevention programs, and improving school climate.

Intervening with aggressive students. As a result of public demands to respond punitively to threats of violence at school through "zero-tolerance" programs, schools often focus disciplinary actions on perpetrators of violence. Policies that focus only on catching and punishing violent behaviors fall far short of the goal of creating a safe school environment. As alternatives to practices such as corporal punishment and ceasing educational services, NASP promotes the use of positive methods of school discipline such as crisis intervention and the application of behavior management principles and strategies. Schools must also make efforts to modify the behavior of students who have engaged or are at risk of engaging in violent behavior. NASP strongly supports systematic efforts to teach social skills and self-control to children and youth as part of a school-wide plan to create a safe and healthy climate conducive to learning.

Implementing victim support programs. Meeting the needs of victims appears self-evident. However, survey data show that most schools respond to antisocial and aggressive behaviors through disciplinary action against the perpetrators, while neglecting to provide appropriate support and counseling for victims. Children who have been the victims of school violence perceive schools as failing to protect them, and as a result they may feel threatened and unsafe while at school. These children display many characteristics common to individuals with Post Traumatic Stress Disorder, including blocked learning and symptoms of serious emotional problems. NASP strongly supports the availability of counseling and recovery programs for victims of school violence.

Establishing school-wide violence prevention programs. NASP encourages the implementation of programs designed to teach peacemaking, peer mediation, and conflict resolution. Such programs are natural bridges between interventions that focus on individual change and those seeking to change the ecology of the school at the organizational level.

Improving school climate. A comprehensive program to reduce school violence includes efforts to affect the general climate of the school itself. Such programs may not focus on specific violent behaviors directly but seek to change the conditions that are, directly or indirectly, conducive to violent acts. Individualized instruction and remedial support where needed can reduce academic failure and frustration that may contribute to violence. Programs to decrease racism and other forms of intolerance, increase appreciation of diversity, and improve levels of trust can also decrease violence by creating a climate of acceptance and understanding and by improving the quality of the relationships among and between students and staff. While school violence may engender a desire to discipline the aggressors harshly, NASP urges school personnel to temper disciplinary responses with efforts to promote cooperation, positive social skills, and peaceful means of resolving conflicts. Addressing school violence must go beyond increasing campus security and establishing procedures to apprehend and punish students who have violated school rules. A comprehensive campaign to end school violence must also encompass efforts to increase support, trust, and caring among students and staff.

Role of the School Psychologist

First and foremost, school psychologists can take a leadership role in encouraging schools to develop a comprehensive approach to violence reduction. School psychologists are trained to a) respond to crises spawned by violence; b) counsel victims; c) implement prevention and intervention programs designed to reduce aggressive behaviors among youths and others; and d) consult with school staff implementing social skills programs and other programs designed to teach peaceful ways to resolve conflicts. These are essential components of a comprehensive school safety plan.

Summary

NASP recognizes that violent acts, wherever they occur, have complex origins and consequences. Efforts to reduce violence at school, therefore, must be multi-faceted. A successful program will ensure the ongoing safety of all students and staff both by creating conditions that discourage violence and by responding quickly and effectively when violence occurs. To be truly comprehensive, however, a violence reduction program will seek to influence student attitudes toward violence, teach students and school staff effective conflict resolution skills, and work to create a climate that promotes tolerance and understanding among students and staff. Such a program will be most effective when blended within broader violence prevention efforts involving local law enforcement, juvenile probation, public health personnel, and other parent and community groups. When an entire community commits itself to reducing violence, the future health and well-being of its children and youth can only be enhanced.

Adopted by the NASP Delegate Assembly
July 14, 1996

For further information about NASP or the role of the school psychologist in preventing and intervening with school violence, contact NASP at 4340 East West Highway #402, Bethesda, MD 20814; or call: (301) 657-0270.

National
Association of
School
Psychologists

Position Statement on Sexuality Education

Education lasts a lifetime and plays a significant role in the decisions we make about our lives. Learning about sexuality is a normal and healthy part of this lifelong process. NASP believes that a comprehensive sexuality education program helps young people develop positive views of sexuality, gives them accurate information regarding health and sexuality, and assists them in acquiring the skills to make healthy decisions regarding their own sexuality now and in the future.

Sexuality education occurs in many settings and requires a collaborative effort by parents, teachers, religious leaders, and medical personnel. The common goal should be to give young people the information they need to develop their own values, to enhance their self-esteem, to provide insight into their relationships with members of both genders, and to better understand their obligations and responsibilities to themselves and others.

Comprehensive Sexuality Education

NASP believes sexuality education should begin early in life and should follow a curriculum that:

- is part of a comprehensive, K-12 school health education program;
- is developmentally appropriate with respect to content and instructional methods;
- respects the diversity of values, beliefs, and cultures within the community;
- has the support of the school administration, the governing school board, and the broader community;
- addresses a wide range of factors related to sexuality such as: AIDS and other sexually transmitted diseases; the abuse of alcohol and other drugs and their effect on personal health; pregnancy prevention; parenting skills; reproductive and sexual health care; accurate information about sexual orientation; healthy decision-making; and effective communication skills, including the skills necessary to refuse unwanted sexual contact;
- includes the prevention of high risk behaviors. Research shows that successful prevention programs provide both accurate information and instruction in the skills necessary to cope with difficult problems and situations. Abstinence Plus programs, which impart accurate information and comprehensive social skills training in addition to sending a strong abstinence message, have been shown more effective than Abstinence Only programs.
- is taught by qualified teachers who have had specialized training in human sexuality and who receive ongoing training and supervision by qualified supervisors.

Role of the School Psychologist

With their training in human development and behavior, psychological and learning processes, and educational systems, school psychologists can play an important role in the integration of appropriate sexuality education into the school system. Recognizing that the issue of sexuality education is controversial, NASP encourages all school psychologists to become informed about the issues and to use their expertise to facilitate effective sexuality education and to provide appropriate related services to high-risk students.

In collaboration with other support and educational personnel, school psychologists can:

- Assist in developing, implementing and evaluating a sexuality education curriculum that is appropriate for the ages, developmental levels, and cultural identities of the student population;
- Provide counseling for students on issues related to sexuality as needed;

- Facilitate parental and community involvement in sexuality education in the home, school, and community;
- Help teachers, administrators, and parents articulate their feelings and concerns regarding sexuality education;
- Respond to those in the broader community who are concerned about sexuality education and its impact on student behavior.

NASP believes comprehensive sexuality education is essential to preserve the health of our children. In the absence of this education, students base their decisions regarding sexual activity, abstinence, birth control, dating, and relationships on the misinformation provided them by peers, television, movies, and what they read in novels and the popular press. Without the intervention of responsible and caring adults, the decisions they make may stem from myth or ignorance. Given the lifelong impact that decisions regarding sexuality can have, NASP believes that comprehensive sexuality education should be an integral part of the school curriculum.

Adopted by the NASP Delgate Assembly, July 1997

Resources for Sexuality Education

Books

Bell, R. et.al. (1988). *Changing Bodies, Changing Lives.* New York: Random House.

Brick, Peggy, et al. (1989). *Bodies, birth and babies: Sexuality education in early childhood programs.* Hackensack, NJ: Center for Family Life Education, Planned Parenthood of Bergen County; (201) 489-1265.

Calderone, Mary S. & Ramey, James W. (1982). *Talking with your child about sex: Questions and answers for children from birth to puberty.* NY: Balientine Books.

Gale, J. (1989). *A parent's guide to teenage sexuality.* New York: Henry Holt and Company.

Lively, V. & Lively, E. (1991). *Sexual development of young children.* Albany, NY: Delmar Publishing.

Madaras, L. (1988). *The What's Happening to My Body Book for Boys, New Edition.* New York: New Market Press.

Madaras, L. (1988). *The What's Happening to My Body Book for Girls, New Edition.* New York: New Market Press.

National Guidelines Task Force (1996). *Guidelines for comprehensive sexuality education: Kindergarten-12th grade, 2nd ed.* NY: SIECUS. (212)819-9770.

Planned Parenthood Federation of America (1995). *How to talk with your child about sexuality: A parent's guide.* NY: PPFA. (800)669-0156.

Website (adolescent sexuality)

<http://www.agnr.umd.edu/users/nnfr/adolesex_talkteen.html>

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